THE UNIVERSITY *of* EDINBURGH

"*Negotiating the Dance of Disclosure*": A Grounded Theory Study of Psychologists' Experiences of Childhood Sexual Abuse Disclosures from Clients in Adult Mental Health

Emma M. H. Ross

Doctorate in Clinical Psychology

The University of Edinburgh

2nd August 2010

I declare that I am the sole author of this thesis and that the work contained herein is my own. This thesis, or any part of it, has not been submitted for any other degree or professional qualification.

Acknowledgements

First and foremost, I would like to express my deepest thanks to the eight psychologists who generously gave their time to participate in this research study.

I would also like to express my sincere gratitude to the following people:

To my research supervisor, Dr David Gillanders for helping me find my research glasses, for his encouragement and support; to my clinical supervisor, Fara McAfee for her kind support throughout the past two years of training and in helping me to find my niche; to Dr Zoe Chouliara and Dr Ethel Quayle, for their generosity and knowledge in qualitative methods and helping to keep survivors on the agenda and to Dr Andy Summers, who has supervised my work in secondary care, has helped me to flourish and shared my sense of humour over the past three years.

To my mother Carol, who has never failed in her love, enthusiasm and support for me and my training and to the loving memory of my father John, who I know would have been very proud.

To my beloved proof-readers (in order of reading): Dr Rachael Fox (for reading in a different time zone); to Graham Findlay (for his unconditional patience, love and cups of tea); to Sarah Nugent, Margi Amin and Joanne Smith (for their enthusiasm, interest and ability to use a semi colon).

And last, but by no means least, I would like to thank all my friends who have kept me in mind, even when I fell off the radar.

Thank you.

Table of Contents

Table of Figures

Word Count: 36,031

Abstract

Hearing disclosures of childhood sexual abuse (CSA) is a clinical reality for many therapists. Psychologists within mental health services are working increasingly with clients who have traumatic histories, including the presence of CSA. Recently there has been a drive towards improving services for adult survivors of CSA, with an emphasis on asking health and social care service-users about abuse. Recent research has demonstrated that the experience of talking about CSA in psychological therapy can be a complex experience for client and clinician with varied consequences for both parties. The research into psychologists' experiences of CSA disclosure has been limited to surveys of psychologists' practice and knowledge and has lacked a scientific approach.

This study aimed to expand on the scientific research into CSA disclosure with a Constructivist Grounded Theory approach (CGT). CGT was used to explore psychologists' experiences of CSA disclosure from clients in Adult Mental Health. Eight psychologists took part in the current study and were recruited from a large Clinical Psychology service in Scotland. Data was collected through semi-structured interviews.

Core categories constructed in this study contributed to a model of psychologists' experiences of disclosure in AMH clinical practice. Core categories referred to "Negotiating the Dance of Disclosure" and "Nurturing the Pre-conditions to Disclosure", which occur in parallel to the therapeutic relationship; whereas "Growing Personally and Professionally" and "Carrying the Weight of the Work" refer to the impact of hearing disclosures and talking about CSA with clients.

Research findings are discussed and the implications of this model in relation to theory and areas of development for research and clinical practice are considered.

1: Introduction

This study focuses on psychologists' experiences of Childhood Sexual Abuse (CSA) disclosure from clients in Adult Mental Health. This introduction offers an outline of the literature relevant to CSA survivors, disclosure of CSA and the implications of CSA disclosure for psychologists who work in Adult Mental Health (AMH). This chapter demonstrates that CSA is often a "hidden" crime affecting people in childhood and adulthood, many of whom will be users of psychology services. CSA disclosures may be made by clients within the context of psychological therapy and offer greater insight into the client's difficulties and inform appropriate treatment. This chapter will also explore the national strategies which attempt to improve services for survivors of CSA and will introduce the changing context of psychology in Scottish mental health services and the role that psychologists undertake in working for adults with histories of CSA.

1.1: Outcomes of Childhood Sexual Abuse in Adulthood

Mental Health

A growing number of studies demonstrate the relationship between CSA and mental health problems in adulthood. CSA has been shown to be a significant risk factor in development of anxiety disorders and phobias (Briere & Runtz, 1988). Post traumatic stress symptoms are common amongst adults sexually abused in childhood (Briere & Runtz, 1988). Individuals with CSA histories are estimated as being twice as likely to suffer from depression (Hill *et al*. 2000). Low self-esteem has been highly correlated with histories of CSA (Kuyken & Brewin, 1999). Eating disorders, including obesity and bulimia have higher incidences amongst female survivors of CSA (Romans *et al.,* 2001). The diagnosis of 'personality disorder' is higher amongst individuals sexually abused in childhood (Murray, 1993). Bi-polar disorder and incidences of mania are linked to CSA (Read *et al.,* 2005). Diagnoses of schizophrenia and other forms of psychosis have been demonstrated as strongly linked to childhood trauma, specifically CSA (Read *et al.,* 2005). Alcohol and drug misuse disorders are high

amongst survivor populations (WHO, 2002). Self-harm and suicidal behaviours are also high amongst CSA survivors (Read *et al.,* 2007; Briere & Runtz, 1988).

Physical Health

CSA has been strongly linked to physical health problems in adulthood. Chronic back and pelvic pain have been linked to CSA (Lechner *et al.,* 1993). There is evidence linking sexual dysfunction, gastrointestinal problems and migraines with CSA in women (Cunningham *et al.,* 1988). Unexplained medical symptoms and non-epileptic or "pseudo" seizures are also linked to individuals who have been sexually abused in childhood (Briere, 1988; Sharpe & Faye, 2006). There are greater rates of high-risk sexual behaviour and sexually transmitted diseases in survivor populations (Greenberg, 2001). Individuals with CSA histories are at risk of problematic pregnancies and tend to have children at a younger age (Mullen *et al.* 1993).

Interpersonal Adversity

The hypothesised relationship between CSA and social adversity in adulthood is complex, however abuse does seem to be a risk factor. CSA has been associated with parenting difficulties (DiLillo & Damashek, 2003). Adults who have been sexually abused in childhood have a greater likelihood of their children also being sexually abused (Finkelhor & Baron, 1986). Evidence also suggests that female CSA survivors are at risk of further sexual re-victimisation and domestic violence, serving to perpetuate the cycle of abuse (Griffing *et al.,* 2005).

In recognition of the links to multiple adverse outcomes in adulthood, the estimated cost of providing health care for female CSA survivors alone in Scotland stands at around £30-60 million each year (Scottish Executive, 2005).

1.2: Prevalence Research

Since research into CSA has gained momentum, prevalence estimates of sexually abusive experiences in childhood have been shown to vary significantly and continue to be met with controversy. Prevalence research has been fraught with methodological variation, definitional problems, and the selection of certain populations, and as yet there is no full agreement amongst the scientific community regarding statistics of childhood sexual abuse.

Much of this evidence has been derived from studies with adult populations. Survey and interview data suggest that CSA histories are found in between 12 per cent and 30 per cent of UK adult females (Baker & Duncan, 1985; McGhee *et al.,* 2003). Between 8 percent and 24 per cent of UK adult males reported histories of CSA (Baker & Duncan, 1985; McGhee *et al.,* 2003). The World Health Organisation estimate that the prevalence of CSA is between 20 per cent and 25 per cent for females and 5 per cent and 10 per cent for males (WHO, 2002).

Research into health service users has indicated a higher prevalence amongst certain populations. CSA histories are more prevalent amongst psychiatric populations, with estimates ranging from 36 per cent to 85 per cent (Bryer *et al.,* 1987; Gallop *et al.,* 1999; Read *et al.,* 2007; Read, 2005). A study of homeless people provided estimates of CSA amongst 32 per cent of males and between 38 per cent and 50 per cent of females (Noell *et al.,* 2001). Studies with substance misusing adults suggested that between 37 per cent and 51 per cent of women and 24 per cent of men had been abused in childhood (Berry & Sellman, 2001; Lab *et al.,* 2000; Simpson & Miller, 2002; Swift *et al.,* 1996; Wilson, 1998). In a study of gay and bisexual men attending genito urinary clinics, 37 per cent reported CSA (Doll *et al.,* 1992). Further, studies of North American crime surveys and student populations have demonstrated that there remains a "hidden population" of CSA survivors that do not tell of their experiences (Finkelhor *et al.,* 1990; Priebe & Svedin, 2008; Smith *et al.,* 2000).

It is likely that prevalence rates and the impact of CSA are underestimated in research and this has been confounded by methodological weaknesses. Research designs using written or telephone surveys may lack sensitivity towards participants and face-to-face interviews may feel too threatening. The extent to which

participants (especially for socio-cultural reasons, males) will withhold information regarding sexually abusive experiences in childhood is unknown. Research may also be criticised for demonstrating inherent biases regarding class and culture for focussing on poorer populations. For example, reviews of Child Protection Service records in America demonstrated that investigations into child abuse are more likely to document victim and perpetrator characteristics (i.e. job, dress, etc) which are typical of socio-economic deprivation while victim and perpetrator characteristics were less likely to be detailed when they were from white and wealthy populations (Drake & Zuravin, 1998). This suggests that factors which may be unique to less 'stereotypical' cases of CSA, victims and perpetrators are neglected in the research.

Studies vary in their definitions of CSA. Those including "contact" and "non-contact" behaviours yield a higher rate than those restricted to "contact" (Andrews et *al.* 2004). Likewise, variations in the age criteria for child victim and perpetrator has shown to influence results (Andrews *et al.,* 2004). Internationally, the research into prevalence data have been criticised and requires considerable review. Within Scotland, recording routine data of abuse incidence within the National Health System (NHS) has demonstrated inaccuracies in reporting, with few cases of CSA being coded for in hospitals (Scottish Executive, 2004).

Inconsistencies in definitions, inclusion criteria and population selection, limit the accuracy and objectivity of estimates of the extent of the problem. Such controversies risk minimising problems faced by society following the aftermath of CSA, with implications for health services and individuals. Nevertheless, there is consistent evidence that individuals with psychiatric diagnoses, substance misuse problems or those that engage in sexually high-risk or self-harming behaviour have a higher likelihood of having experienced CSA than the general population. Professionals working in relevant services can expect to encounter CSA survivors in routine clinical practice.

1.3: Disclosure of Childhood Sexual Abuse

In the literature, the term "disclosure" is used broadly within the context of informing another person about the abuse (Bradley & Follingstad, 2001; Denov, 2003; Everill & Waller, 1995; Foynes *et al.*, 2009; Somer, & Szwarcberg, 2001). Although the term seems rather self-explanatory, researchers have attempted to refine the understanding of disclosure. Alaggia (2004) argues that "disclosure" and "telling" of CSA refer to distinct developmental stages. *Disclosure* is more commonly used in reference to a child's reporting of abuse; whereas *telling* is more often used to describe an adult survivor reporting their abuse. Whereas Jones (2000) advocates that researchers refrain from using the term at all, to minimise ambiguity in reporting the behaviour. However, Lindblad (2007) acknowledges that the term is so scientifically and clinically established that this is not possible. Instead he advises that whenever the term is used, authors should be explicit about the context with which it is *operationalised.* For the purposes of this study, disclosure will refer to its broadest sense of an adult telling another person about sexually abusive experience(s), regardless of whether they have disclosed before.

Prevalence of Disclosure and Delay

Substantial evidence exists that many people who have experienced CSA do not disclose this. A North American telephone survey of 2,626 adults revealed that 27 per cent of women and 16 per cent of men reported a history of CSA, 38 per cent of whom had never disclosed their abuse to anyone prior to the interview, representing 42 per cent of abused males and 33 per cent of abused females (Finkelhor *et al.*, 1990). These findings were echoed when Smith and colleagues (2000) examined data from another USA telephone survey for CSA disclosure. Of the 3,220 women surveyed, 288 (9%) reported that they had been raped in childhood. It was estimated that almost one half (48%) of the victimised women only disclosed this after at least five years and 28 per cent of the women had not disclosed the abuse prior to the interview.

Most incidences of CSA are not disclosed at the time of the offence(s) with a minority of offences disclosed to criminal justice authorities (Mullen *et al.,* 1993; Russell, 1986; Saunders *et al.*, 1992). In a study of patterns of disclosure and non-disclosure amongst male (n=2,015) and female (n= 2,324) adolescents, only 9 per cent of the abused females and 3 per cent of the abused males had disclosed their abuse to any type of professional (Priebe & Svedin, 2008).

Studies examining the delay of CSA disclosure with adults have reported mean delays between 3 and 18 years (Frenken & van Stolk, 1990; Lamb & Edgar-Smith, 1994). Sixty-four per cent of the women in Roesler and Wind's study (1994) only disclosed in adulthood. Hanson *et al.* (1999) found that nearly 83 per cent of female childhood rape survivors did not report the rape in childhood and Arata (1998) found that almost two-thirds of the females participating in the study had not told anyone at the time of the abuse.

In a Scottish qualitative study of male survivors, Nelson and Hampson (2009) found that three quarters of participants had been unable to disclose their abuse throughout their childhood.

Such studies show disclosure rates to vary and researchers have attempted to understand the factors linked to delay and non-disclosure of CSA.

Predictors of Delay

Most survivors of CSA are reluctant to disclose their abuse, even well into adulthood. Research points to multiple factors potentially involved in disclosure situations, such as relationship to the perpetrator, age at onset of abuse, victim gender, and characteristics of abuse.

Some authors have hypothesised that delays in CSA disclosure are linked to the nature of the relationship between victim and perpetrator. Studies have reported that CSA disclosure was more likely to occur when the perpetrator was a stranger rather than a member of the victim's family and longer delays of disclosure have been

associated with abuse by family members rather than non-relatives (Hanson, *et al.*, 1999; Smith *et al.*, 2000; Ussher & Dewberry, 1995). However, other findings have been unable to demonstrate an association between relationship to perpetrator and disclosure (Arata, 1998; Lamb & Edgar-Smith, 1994). The use of perpetrator identity to gauge the nature of the relationship to victim may not necessarily be a robust concept. For example, children may perceive a closer relationship to a neighbour than a parent or step-parent which would confound results. Furthermore, the relationship to the perpetrator may be confounded by the complex interaction of variables related to the abuse or the sampling methods used. Nevertheless, these studies did indicate that closer relationships to perpetrator link to decreased disclosure at the time of the abuse. Further research is however required in this area.

For girls, non-disclosing behaviour has been predicted by: the severity or frequency of the sexual abuse, the girl's relationship to the perpetrator at the first instance of victimisation and their perception of parental bonding. Teenagers that perceived their parental relationship as caring and not over-controlling were more likely to disclose their abuse than children with any other parental bonding style (Priebe & Svedin, 2008). Of the adolescents that disclosed sexual abuse, they did so most frequently to friends, with the abuse remaining 'hidden' from adult social networks.

The attachment relationship has also been implicated in delay of disclosure (Freyd *et al.*, 1996). Freyd and colleagues have proposed *Betrayal Trauma Theory* (BTT) to account for memory bias for traumatic incidents in childhood. This model suggests that memory impairment depends on the extent to which the trauma constituted a betrayal. Traumas occurring in the context of betrayal(s) of trust by an attachment figure are associated with greater disruption in memory of the abuse. In instances where a child is aware of the abuse by an individual that they depend upon, they may risk causing ruptures within the attachment relationship (i.e. by protesting, retreating or attacking) in trying to integrate their experiences. In following the BTT model, if a child can decrease their awareness of their abuse by a care-giver, this serves as a strategy to maintain care-giver/child attachment, regardless of how traumatic the attachment is. Non-disclosure behaviour can be seen as an attachment strategy, where attachment is more vital to the child than escape from harm (Foynes *et al.*,

2009). Foynes and colleagues (2009) hypothesised that the greater the relationship betrayal, the greater the amount of time will have elapsed before the victim discloses. They tested this by measuring trauma histories with 202 undergraduates. The results demonstrated that 47 (23.3%) reported CSA; 73 (36.1%) reported emotional abuse; and 97 (48%) reported physical abuse. Further, 55 per cent of the participants who reported sexual abuse in childhood delayed their disclosure by at least one year. 12 per cent of the participants, who had experienced CSA, reported having never disclosed their abusive experience until they were asked in the study. These results supported the hypothesis that greater delays of disclosure were associated with closer relationships between perpetrator and child when looking at all forms of childhood abuse. Given the small sample, it was not possible to draw a similar conclusion with each sub-type of child abuse (physical and sexual). However, given that a small number of the undergraduate participants reported being abused by attachment figures, there appears to have been insufficient numbers to allow sufficient analysis of specific abuse type. In fact of the 73 participants who reported CSA, they were almost three times more likely to define the relationship with perpetrator as "very close" (65.3%) than "not very close". This limited the conclusions that could be drawn regarding delays in CSA disclosure.

Why is disclosure important?

Disclosure is theorised to serve intrapersonal and interpersonal functions. These include: a desire for justice, requesting help (practical and emotional), clarification of need and describing coping behaviour, increasing another's understanding of the individual, a vehicle for emotional catharsis and a sense of empowerment for the survivor (Alaggia, 2004; Foynes *et al.*, 2009).

CSA history is an important factor in therapeutic formulation and treatment for trauma (Bradley & Follingstad, 2001; Herman 1992). Issues relating to abuse and the betrayal of trust will often be important in establishing a therapeutic relationship (Jacobson *et al.,* 1987). Some authors argue that psychological formulation requires a full understanding of the client and of early experiences, particularly trauma, in order

to offer appropriately tailored intervention (Briere, 1989; Jacobson & Richardson, 1987; Read *et al*., 2007).

Response to disclosure is no less important for the client. Response may determine whether that individual feels able to discuss it in future, to seek support or counselling or to simply feel that they have been believed (Nelson & Hampson, 2008).

The impact of disclosure for an individual may be enormous:

> *"For people who suffered CSA, confiding may signal the beginning of a move from the role of silent victim to that of indignant survivor" (Somer &* Szwarcberg, 2001, *p.332).*

Equally, non-disclosure or delayed disclosure may serve to permit the abuse to continue, to block the individual from receiving appropriate treatment and to create stressful conditions which exacerbate stress and vulnerability to psychological distress.

Pruitt & Kappius (1992) theorise that non-disclosure of CSA may contribute to deterioration in psychological functioning due to continued repression of abuse memories. Undisclosed abuse may also mean that a survivor is a chronic user of psychotherapeutic services. Failure to deal with the issue of CSA with clients has been linked to a number outcomes: maintaining 'repression' of the abuse and therefore exacerbating symptoms, failure to deal with the problem, prolonging therapy, inadequate information compromising both psychological formulation and treatment, maintaining both the survivor's vulnerability to abuse and that of their own children and perpetuating the cycle of risk (Browne & Finkelhor, 1986; Craine *et al.,* 1988; Cole, 1988; Pruitt & Kappuis, 1992). The notions that earlier disclosure of CSA may alter the developmental trajectory of a child and even disclosure earlier in adulthood may greater enhance recovery are complex. Given the sheer volume of variables which may be implicated in such outcomes (i.e. details of abuse, length of delay between abuse and disclosing, coping strategies, social support, perpetrator)

attempts to investigate these hypotheses would be significant undertakings. Consequently, at present there is little empirical evidence to support such hypotheses.

Disclosure and Social Support

In a review of the literature into CSA disclosure amongst adults, McNulty and Wardle (1994) found evidence that the point of disclosure places the survivor at increased risk of psychological difficulties. One psychodynamic theory to account for this is that the release of repressed and unassimilated abuse material marks an increase in symptoms of psychological problems and if/when successful assimilation of this material is achieved (often through therapy), psychological functioning will improve. As such, therapeutic involvement with individuals disclosing for the first time will require a "controlled disclosure", mediated by the therapist to achieve full release of repressed material.

Psychodynamic theory aside, other theoretical factors may be implicated in the increase of distress caused by disclosure. Cognitive-Behavioural and Emotional-Processing models of trauma therapy require the client to *re-visit* their experiences through talking and imagery to weaken emotional responses (Briere, 2002). This process of therapy is likely to be triggering of distress in the client. Use of social support is widely regarded as a buffer against the effects of stress (Coker *et al*., 2002). However, disclosures may place an additional strain on that support network (e.g. if others have any relationship with the perpetrator, or the supportive others may also have histories of abuse to contend with). As survivors of CSA have an increased risk of psychological problems and psychiatric diagnoses, they may be at greater risk of an impoverished social support network in the first place. Consequently, disclosure may put strain on relationships or even test an already diminished support network.

Responses to Disclosure

Responses to disclosure are therefore vitally important. Investigators working with CSA survivors report a wide variety of responses from professionals to disclosure, in terms of appropriateness and supportiveness.

Denov (2003) conducted a qualitative investigation into professional responses to disclosures from survivors of female-perpetrated CSA. 14 (7=female; 7=male) participants disclosed CSA to a total of 25 professionals, including police officers, child protection staff, psychologists and psychiatrists (unfortunately this study did not provide more information about the specific responses from each profession). 43 per cent (n=6) of participants described experiencing only "positive" responses from professionals following their disclosure, 14 per cent (n=2) reported only "negative" responses, and another 43 per cent (n=6) reported receiving both "positive" and "negative" responses from professionals. Participants felt that "positive" responses had come from a total of 12 professionals and involved a supportive and understanding stance where they never doubted the truth or seriousness of the abuse. Thirteen of the professionals gave negative responses; demonstrating their discomfort at, or resistance to, talking about female-perpetrated sexual abuse; doubting or minimising the abuse or expressing shock at the abuser's gender. Clients experiencing positive responses from professionals felt that this had been validating for them and had contributed to their recovery. Negative responses on the other hand, appeared to have adverse affects on the survivor, increasing their distrust of professionals, contributing to the survivor's sense of anger and causing them to question or deny the seriousness or actual incidences of abuse. This would support the view that perceived negative responses to CSA disclosure are *a-therapeutic* and even harmful to the survivor's recovery.

Other studies have demonstrated professional responses in a largely unfavourable light. Frenken and Van Kolk (1990) reported responses to disclosures of incest. They describe survivors feeling shamed and humiliated, professionals not exploring further into what was revealed, and ridicule or disbelief. Five participants surveyed by Frenken and Van Kolk (1990) even reported that they had encountered direct sexual advances from professionals when they had disclosed CSA.

Two more recent studies involving CSA survivors and professionals in Scotland have produced contradicting results. Nelson and Phillips (2001) conducted a series of interviews with 22 female CSA survivors who had been recruited through their involvement with voluntary services and who had previously been hospital inpatients in Edinburgh. CSA disclosures were made to professionals within statutory services (General Practitioners, Psychiatrists and Clinical Psychologists). Participants reported that professionals rarely asked about abuse, their histories had been dismissed or they were perceived as "difficult" patients. Positive experiences of disclosure were more commonly linked to staff from non-statutory mental health and survivor services. However, the impact of this study was limited by a number of issues relating to the transparency of the study, including a failure to report the qualitative methodology and procedure used, potential biases from participant selection and a failure to seek out 'negative cases' through sampling, in other words, no attempt to seek out differing views and experiences from other participants.

A study by Chouliara *et al.* (*in press*) demonstrated a more transparent qualitative research design using Interpretative Phenomenological Analysis with the aim of accessing the experiences of both survivors and professionals. Participants included 13 CSA survivors who were at the time accessing services that provide "talking therapies" for sexual abuse in NHS settings (n= 7) and the voluntary sector (n= 6), and 31 professionals who work with CSA survivors (16 from NHS services and 15 from voluntary services).

Important points emerging from these studies related to both the benefits of talking therapies and the challenges of using/ providing services. Survivors emphasised the importance of being given a safe place to disclose their CSA, where they did not feel judged by the therapist who was able to "normalise" their reactions to the abuse. Challenges which were described by survivors in relation to professional response to disclosure concerned their involvement in child protection systems. NHS services operate under strict child protection procedures where workers are required to pass on concerns regarding risk to children to child protection services. In many services, trained health professionals act as liaisons or points of contact where staff can take their concerns. On hearing information relating to the risk of ongoing abuse to

children, staff members are required to act on this. Survivors in the study by Chouliara *et al.* described this aspect of professionals' responses difficult. Overall, the survivors in this study described more positive responses from NHS mental health professionals than were found by Nelson and Phillips (2001). To some extent, this may reflect the discrepancies in rigour, transparency and coherence of methodologies used in both studies, but may be indicative of a change in practice amongst professionals working in statutory mental health services.

Disclosure may occur when the survivor perceives a supportive relationship to provide a *safe space* to disclose or on the advice or inquiry of a therapist, or made by another party (Alaggia, 2004; McNutly & Wardle, 1994). The subsequent response to the disclosure may be experienced by some as hostile, rejecting or minimising and act as a barrier to the survivor accessing subsequent support from that relationship. Draucker and Petrovic (1996) investigated the healing process of 19 male survivors of CSA using a Grounded Theory methodology. Survivors' narratives illustrated an "explosion" of insight and memories relating to their abuse which were associated with initial disclosure. Many of the participants experienced periods of intense anxiety and distress following this, which then gave way to relief and hopefulness. An adverse response to disclosure when combined with re-experiencing abuse memories and heightened levels of distress may make the individual more vulnerable to increased social withdrawal and subsequent development or worsening of psychological difficulties.

Everill and Waller (1995) investigated whether an adverse response to CSA disclosure had a similar link to psychopathology in a non-clinical sample of 69 female undergraduate students. Participants were recruited under the guise of an investigation into eating attitudes and they were not informed that the study would look at specific experiences of sexual abuse. Of the 69 women, 48 reported some form of sexually abusive experience occurring before the age of 18 years of age. 34 women reported having made at least one attempt to disclose. Seven described the responses to their disclosures as unsupportive whereas 27 reported receiving a supportive response. Positive responses to disclosure were more commonly offered by friends, whereas adverse responses were more commonly given by family

members. Perceived adverse responses to disclosure were associated with greater levels of psychological dysfunction and greater representation of oral control behaviour (eating control and the perceived pressure from others to gain weight). Controlling behaviour in terms of oral and dietary behaviour may be a maladaptive attempt to develop internal locus of control following receiving a negative response to disclosure where their sense of agency has been denied (Everill & Waller, 1995). Conversely, positive response to disclosure may mediate internal locus of control.

Perceived adversity of response to disclosure was also linked with greater levels of self denigration (Everill & Waller, 1995). Unsupportive responses to disclosure serve to reinforce beliefs of self-blame and self punishment that are commonly cited in the sequelae of CSA (reviewed in Wenninger & Ehlers, 1998). Perceived adverse responses to disclosure was also associated with dissociative experiences in Everill and Waller's (1995) study. Dissociation may be a means of coping not only with the trauma of the abuse but to defend oneself against self-denigratory beliefs and a sense of the betrayal implied by another's adverse responses to disclosure. The analyses of results in this study were not specific to CSA-type (i.e. incest vs. non-incest abuse) when examining the nature of response to disclosure from other parties. It may be that the levels of psychological distress and dysfunctional beliefs may be linked to factors more specific to family dysfunction, rather than family-member response in isolation. Despite the limitations of this study, the results indicate that receiving an adverse response to CSA disclosure may represent a risk factor for development of dysfunctional beliefs and psychological problems, while supportive responses were associated with positive adjustment and recovery for the survivor (Everill & Waller, 1995).

Language and Disclosure

Studies have shown that general types of questioning (i.e. "have you been raped?") are associated with lower prevalence rates of sexual assault and rape than questions which describe specific behaviours that constitute rape (Fricker & Smith, 2003). Moreover, studies have indicated that survivors of sexual assault do not necessarily characterise their experiences as abuse or rape (Hamby & Gray-Little, 2000). The

context of the questioning has also been shown to have influence disclosure rates. An example for this came from a crime-focussed survey where a respondent had never reported sexual assault prior to the study as she did not view her experience as a crime (Smith *et al.*, 2000).

Fricker and colleagues (2003) examined the use of research context and question type in inquiry on disclosure rates amongst college students. Short videos were created for the purposes of this study in order to test the hypothesis that "context" of a study about sexual abuse influences the rate of abuse-reporting, whereas a study that does not introduce a specific context will yield lower rates. Five behaviourally-specific questions and one label question were used to test the hypothesis that behaviourally specific descriptions of abuse would yield higher rates of abuse disclosure than labels of abuse. An example of a behaviourally-specific question was:

"Before the age of 18, did anyone, male or female, ever put their fingers or objects inside your anus or (for women) *vagina when you didn't want to?"* (p.268).

The label question was: *"Before the age of 18, were you sexually abused?"* (p.268).

A short film was created and shown to every participant, in which they were instructed to answer questions honestly and advised that all responses were confidential (film part I). To set context, a subsequent piece of film included detailed information about sexual abuse, the behaviours which constitute sexual abuse of adults and children, behaviours which perpetrators use to force victims to comply, rates of disclosure, and the potential effects of sexual assault (film part II).

A total of 236 students were randomly assigned to one of four conditions where they were asked about sexual abuse: 1) non- context with questions labelling "abuse" (e.g. film part I only with abuse- labelling questions), 2) non-context and behaviourally specific questions (e.g. film part I with behaviourally specific questions), 3) context-specific and labelling questions (e.g. films part I & II with abuse-labelling questions), and 4) context & behaviourally-specific questions (e.g. films part I & II with behaviourally-specific questions).

Greater rates of CSA and rape disclosure were found within groups that used behaviourally specific questioning, rather than using labels of abuse. The use of an information film to set the context of the study yielded no differences in disclosure across the four groups. One potential limitation of this study design is that there was only one specific label used for abuse. It is unclear whether using other labels such as "rape" or "sexual assault" may have influenced participants' responses differently. Nevertheless, the results indicate that behaviourally specific language is likely to prove most effective in trying to get an accurate history from clients using mental health services rather than using specific labels of "abuse".

Self-definition of Abuse

The extent to which an individual self-defines their experience as abusive is also a potential reason for non- or delayed disclosure. Holmes (2008) conducted a USA community-based probability sample of men who were screened for abusive "childhood sexual experiences" (CSE; author's definition). Participants were asked whether they defined abusive sexual experiences in childhood as "Childhood Sexual Abuse". People with abusive CSEs were less likely to self-define them as CSA if they were African-American, identified themselves as gay or bisexual, had low-parental care, had no siblings and had experienced physical childhood abuse. *Non-definers*, i.e. males in this study who had abusive childhood experiences but did not define it as CSA, were more likely to have experienced penetrative sexual abuse. Non-definers were also more likely to have been abused by multiple perpetrators and experience a greater number of sexually abusive events in childhood rather than men who *did* define their experiences as CSA. Non-definers were also more likely to have sex under the influence of alcohol or drugs. Heterosexual non-definers had more sexual partners and a greater history of sexually transmitted disease than heterosexual definers.

Given that the non-definers had reported a greater severity and frequency of multiple sexually abusive experiences, it may be that this was a context in which participants saw their experiences as 'typical' or non-abusive, placing them at risk of further victimisation. However, severity of abuse may place survivors at greater risk of

engaging in dangerous behaviours and suffering adverse outcomes rather than this being caused by non-definition *per se*. In being unable to define one's experience as CSA, survivors may be less likely to perceive that they have a choice to engage in alternative, healthy sexual experiences. Consequently, this may decrease their likelihood of learning new adaptive behaviours which minimise personal risk if they do not perceive themselves to have been abused.

Holmes (2008) results support the view that defining one's sexually-abusive experiences may be a protective factor in terms of later life outcomes for men. Equally, non-defining one's abuse may place the individual at risk of a number of adverse consequences. Non-defining may be a product of a sense of being complicit in the abuse (e.g. having experienced sexual arousal during the abusive acts), or a lack of personal boundaries confounded by being alone in an uncaring family dynamic, or a form of psychological defence against disruptions within an important relationship. Holmes hypothesised that emotionally avoidant coping mechanisms (i.e. sexually high-risk, substance-misusing behaviours) may perpetuate the likelihood of personal risk. These findings have implications for how CSA inquiry may be made and also how psychological therapy can be adjusted around the clients' own labelling of their experiences.

Models of Disclosure

Disclosure may occur without any professional involvement, (made as a matter of course in the development of long-term relationships with others. Disclosures may be made as a result of research into prevalence to the researcher. 'Disclosure-by-other' refers to incidents where a family member or friend has either observed or suspected sexual abuse and disclosed this to another (McNulty & Wardle, 1994). Alaggia (2004) found three main types of disclosure in her qualitative study into disclosure with 24 female survivors of CSA: purposeful disclosure refers to the intentional use of verbal (i.e. telling) or non-verbal (aggression, withdrawal) behaviour to communicate problems. Intentional withholding of abuse emerged as a category emerged from narratives of survivors that had withheld their disclosures following a conscious decision-making process. Factors in this decision were concerns that they

would not be believed, self-blame, shame, fear and avoidance of causing distress to others. Participants remained resolute in their decision to withhold their disclosures well into adulthood. Their decision to eventually disclose was often influenced by geographical distance from their perpetrator or having distanced themselves from threats used to subdue the individual as a child (such as being removed from the family of origin and placed in care).

Prompted/ elicited disclosure refers to disclosures which came about by the survivor's interaction with another individual or stimulus which prompted them to disclose. A sub-category of this was "triggered" disclosure which corresponded with almost one third of participant's narratives. Moreover, until this time, participants reported a total lack of recall of their abuse throughout childhood. The triggering events were described as sudden flashbacks, or other recollections as a result of hearing the disclosures of others, or seeing abuse-related stimuli (e.g. a survivor seeing their own child, naked, in the bath). Forty two percent of the participants had disclosed immediately following the abuse and only six of these had been purposeful disclosures. The remaining 58 per cent of the sample had not disclosed until adulthood. Purposeful and elicited disclosures made up 42 per cent of the total disclosure types. The most significant mode of disclosure was purposeful, with 6 participants disclosing purposefully. Examples of elicited/ prompted disclosures occurred most when disclosures had been delayed until adulthood and this was within the context of a psychotherapeutic relationship.

Alaggia's (2004) study demonstrated that survivors disclose CSA in varied and complex ways. In addition to the disclosure patterns identified by previous research, this study widened the knowledge-base regarding disclosure behaviour. The categories emerging from this study embodied complex aspects of disclosure embedded in contextual factors such as human development, memory and the therapeutic relationship, which will be relevant for people working with survivors.

When child sexual abuse has occurred, then the optimal time to disclose appears to be immediately following the abuse, where the individual is believed and supported through their journey of recovery. However, the research into delayed disclosure serves to remind professionals that disclosure will occur at any age. Further, it is

likely that disclosures of CSA narratives will be made to professionals working therapeutically with survivors, some may have disclosed to others prior to this and there are those who will be telling for the first time. On hearing disclosure, the professional should bear in mind that the individual may have encountered an array of responses (helpful or otherwise). Further, professionals must bear in mind that time does not necessarily alleviate the negative effects of CSA, i.e. just because a disclosure is delayed; this does not necessarily mean that the abuse(s) have been worked through.

Clients' Experiences of Disclosing to Mental Health Professionals

Studies have demonstrated that survivors who make disclosures of CSA to professionals do not always receive a consistent level of support from mental health services. Frenken and van Stolk (1990) analysed contacts between survivors of intrafamilial CSA and mental health professionals where CSA disclosures had been made. They demonstrated that on average, 3.5 professionals were disclosed to over the years. The authors of this study described it as *"the long march through the consultation rooms"* where a survivor is passed onto other services once they disclose or remove themselves from one service to find support elsewhere (Frenken & van Stolk, 1990, p.259). In the first contact with a professional where incest was explicitly disclosed by the survivor, 61 per cent of professionals did not inquire further into what they had been told; by the time of the second disclosure to a professional, 51 per cent of professionals did not delve any further into the abuse; by the third disclosure, 50 per cent of professionals did not acknowledge it; and by the fourth time of disclosure, 38 per cent of professionals ignored the matter. Perhaps surprisingly, many survivors did not give up in their search for professional help altogether. However, this study did not follow up service-users that discharged themselves from mental health services and whether they had managed to gain supportive responses from other sources. Further, researchers did not analyse the data according to which professionals *did* engage in open conversations about abuse with clients.

The response of professionals to disclosure was strongly linked to this pattern of multiple contacts amongst survivors. Many of the women reported that their disclosures had been met with belittlement, blame, astonishment or disbelief. Alarmingly, five of the 50 women interviewed reported being sexually victimised by the professional to whom they had disclosed. This research strongly supports the notion that the type of response to disclosure impacts on many clients' experiences with mental health services.

Lothian and Read (2002) conducted a questionnaire-based study into the experiences and opinions of 74 mental health service-users and then conducted face-to-face interviews with 11 of these participants. 78 per cent of the service-users reported that they had not been asked about abuse at initial intake assessment; 64 per cent of participants reported experiencing at least one form of childhood abuse; and 69 per cent of them believed that there was a connection between their abuse and their current mental health problems. However, 25 per cent felt that the diagnosis received following this initial interview did not accurately describe their problems. Subsequently, Read *et al.* (2007) advocated the use of routine abuse inquiry by mental health service-providers, providing a framework of question-type to support sensitive inquiry. Routine inquiry may encourage the client and professional to work collaboratively towards understanding the client's difficulties.

Routine inquiry into abuse histories has demonstrated a significantly higher disclosure rate in mental health services than when this practice is inconsistent. For example, 'spontaneous' disclosures occurred in between six per cent and eight per cent of patients admitted to psychiatric services in New Zealand, but 70 per cent and 82 per cent disclosed when inquiry was routinely practiced (Briere & Zaidi, 1989; Read & Fraser, 1998). This strongly supports the view that disclosures are rarely 'out of the blue', whereas asking specific questions is likely to encourage the client to disclose.

Read *et al.* (2001) reviewed 200 patient case files from an outpatient psychology service. They found that CSA was a stronger predictor of suicide than even depression. Further, as demonstrated in section 1.1, CSA represents a risk factor for adverse outcomes in terms of self-harm, eating disorders, and substance-misuse.

Disclosure of CSA stands as a significant factor in any risk assessment undertaken by professionals. So long as this can be done sensitively and respectfully, client care is likely to be enhanced if clients are helped to disclose.

1.4: Disclosure and Inquiry- Professionals' Experiences

There is increasing emphasis being placed on the response by members of staff within mental health services to disclosures of CSA within the important task of gathering accurate client histories to inform care provision. Read and associates have made a significant contribution to raising awareness in mental health services of the importance of CSA disclosure and how we respond to hearing histories of abuse (Cavanaugh *et al.*, 2004; Read *et al*., 2007).

The extent to which mental health professionals openly ask about abuse varies considerably and this has been linked to a number of factors. Lab *et al.* (2000) found that if a service-user was male, mental health professionals were less likely to ask about CSA and less likely to consider it as a factor important to that client's presentation. A New Zealand study found that the diagnosis of a severe and enduring mental illness such as psychosis or schizophrenia made professionals less likely to ask about childhood abuse as they feared that the question may induce "false" memories in the patient (Cavanaugh *et al.,* 2004). Young *et al.* (2001) found that amongst the professionals surveyed, reasons for not asking included the risk of upsetting the patient and that asking was not deemed a primary concern for the patient's treatment.

In a survey of professionals working with incest survivors, a focus was placed on what they thought were barriers to effective handling of incest disclosures (Frenken & van Stolk, 1990). Here, their biggest barriers were perceived lack of therapeutic knowledge and skills and a wish to avoid the disturbing emotions that they either felt, or predicted to feel, when working with people with incest histories. Specifically, professionals reported experiencing anger towards the perpetrator, embarrassment and disgust, or an over-identification with the victim's experiences and generally feeling powerless and overwhelmed.

Handling Disclosure

Babiker (1993) stated that sensitivity and compassion are essential when responding to disclosures of sexual abuse. Decisions regarding what to do in response to these disclosures requires time for reflection in order to choose a course of action in which the interests of the survivor and wider society are best served. Furthermore, in terms of the professionals working with clients who *do* disclose abuse, Babiker (1993) emphasised the need for a separate source of supervision which is not provided by line manager or multidisciplinary team in order to adequately address the issues of *countertransference* which are likely to arise. He advises that inexperienced staff and staff in training should neither inquire into the possibility of abuse nor ask patients that have disclosed about the details of their experiences, even if patients approach untrained members of staff and make "*tentative attempts at disclosure*" (p.288). While Babiker advises that disclosure and particularly inquiry, is handled by a trained and supervised qualified professional, the reality may be that staff members may be highly avoidant of engaging patients in discussions which may lead to a disclosure. Avoiding the subject of abuse histories may communicate to the patient that their story is *unbearable*, in turn reinforcing the silence, secrecy and isolation that is assumed to reinforce non-disclosing behaviour. As an alternative approach, it has been proposed to train and support *all* disciplines of staff, from *all* levels to be able to hear disclosures of abuse and to respond effectively (Nelson & Hampson, 2008; Nelson & Phillips, 2001; Read *et al.*, 2007; Scottish Executive, 2005).

Research has shown that when abuse is suspected within the histories of adult clients, mental health professionals do not pursue this (Frenken & van Stolk, 1990). One of the most common reasons stated for this was that the clients should raise the issue of their abuse by themselves before the professional would be willing to discuss it. In a North American study by Pruitt and Kappius (1992), many professionals reported that they would only inquire about abuse with a client if they presented with *"symptoms* [to have] *been caused by sexual abuse"*[1] (p.477). However, this approach

[1] To date, there is no research which has been able to identify a single set of symptoms which characterise the effects of CSA and support a "post-sexual-abuse-syndrome" (for a review, see Beitchman *et al.* 1991, p.538).

at best is inconsistent and at worse, dangerous, risking the under-detection of CSA and delivering insufficient care.

Much of the research into the practices of mental health professionals relating to CSA inquiry has been undertaken by using questionnaire and survey methods. Pruitt and Kappius (1992) surveyed 105 private practice therapists regarding their current practice and their views on asking clients about CSA. Therapists who were younger in age (35-52) and therapists who were less experienced (7-19 years of practice) were more likely to ask clients about CSA. However, older more experienced therapists were less likely to do this.

In a study that focused on the factors which influence UK clinical psychologists' hypotheses and clinical judgement, participants were presented with a detailed case summary of a fictitious client which incorporated "indicators" that the client had been sexually abused in childhood (Holmes & Offen, 1996). This included dissociation, sleep disturbance and night time fears, fears of an intruder, anger and rage excessive to the apparent trigger, a loss of desire for sex and low self-esteem. Psychologists provided their hypotheses of predisposing factors for the client. The gender of the "client" was manipulated to investigate whether client gender had any influence on their judgement. Psychologists were much more likely to hypothesise that there was a history of CSA if the client was female. Female psychologists were more likely to hypothesise CSA than male psychologists, regardless of the client's gender. Psychodynamic and humanistically-orientated clinical psychologists are more likely to hypothesise CSA than Cognitive Behavioural Therapy (CBT)-oriented clinicians (in female clients only) despite CBT being a recommended approach with abuse survivors (Briere, 2002). Regardless of theoretical orientation, clinicians generally believed that CSA was a more important therapeutic focus for female clients than males, indicating a belief that males are less at risk of CSA than females and males are less affected by CSA than females. This study demonstrated that clinical psychologists may be less open to the likelihood that male clients may have

been sexually abused in childhood than they would if the client was female[2]. Such beliefs may maintain a minimisation of the impact of CSA on males and a lack of adequate services for them. Clinicians who are not open to the possibility of abuse may be less likely to ask (Holmes & Offen, 1996). Further, they may place less importance on creating a therapeutic environment where males feel able to discuss abuse.

Another UK study, this time of psychologists and psychiatrists, surveyed inquiry practice (Lab *et al.,* 2000). Whereas 50 per cent of psychologists in this study reported that they never ask male clients about abuse, only 2 per cent claimed to ask all the time. 75 per cent of psychologists responded that males should only sometimes be asked about abuse. They also stated that they were less likely to refer those that did disclose to other agencies for help. Reasons for not asking male clients about abuse included a concern about the emotional impact on the client or the clinician. This included: the concern that asking could be too intrusive and inhibit engagement; that it is inappropriate to ask when presenting problems are *"irrelevant to sexual abuse"* (Lab *et al.,* p.396); the client may be too distressed or actively psychotic to ask; that it may make the client angry or violent; asking causes discomfort; it could cause a decline in functioning; it may not be the most pressing issue to deal with at the time; or there may be insufficient resources available to manage the 'consequences' of the disclosure. Further, psychologists who were less likely to ask reasoned that inquiry may cause "false memory syndrome". This study also indicated that the methods employed by mental health professionals to inquire were largely inconsistent, often only asking about abuse when they remembered to do so. Whereas 50 per cent of psychologists reported that they had received sexual abuse training, only 25 per cent were confident enough of that training had been sufficient to be able to inquire about abuse histories with male clients.

The authors of this study hypothesised that the lack of inquiry with male clients of mental health services results from professionals: 1) not recognising the prevalence

[2] Although there is some evidence to suggest that CSA prevalence differs between males and females, there is also evidence to suggest that males are more likely to withhold disclosures of abuse (Nelson, 2009; Sorsoli *et al.* 2008).

of CSA amongst adult males, 2) underestimating the impact of CSA on adult males, 3) fearing the consequences of asking about abuse being unmanageable for the professional, and 4) being insufficiently trained.

In a New Zealand study of professional therapists, 63 psychologists and 51 psychiatrists completed questionnaires about timing and circumstances of inquiry practice (Young *et al.*, 2001). 62 per cent of respondents reported that the best time to inquire was once rapport had been established between clinician and client, while 47 per cent of clients selected the response: "usually on admission/ initial assessment, unless the client is too distressed". Clinicians were also less likely to ask a client about abuse if they were accompanied by family members, although they would be more likely to re-inquire at some point in the future if the client had said no to begin with. However, the researchers did report that psychologists reported that reasons for not asking would be the risk of provoking "false memories" in the client and their opinion that CSA was so rare that there would be little reason to inquire about it. Psychologists who received training on CSA inquiry were more likely to inquire about abuse with their clients.

Day *et al.* (2003) administered a survey to mental health professionals within the UK. Respondents demonstrated a comprehensive knowledge of the effects of CSA on adults. However, staff generally reported feeling under-equipped to work with survivors of CSA. Many rated themselves as under-confident and uncomfortable working with this client group. Day *et al.* (2003) hypothesised that only small amounts of training serve to heighten professionals' anxieties, implying that some professionals may elect to avoid addressing issues related to abuse with clients in order to escape the burden of responsibilities that they do not feel sufficiently competent to carry.

Young and associates (2001) summed up the risks of non-inquiry for the client:

"If, for whatever reason, we wait for spontaneous disclosures, we will fail to identify most of the abuse. If we don't ask, we cannot offer help" (p.411). Inquiry may be an essential aspect of providing help to mental health clients.

Professionals are more likely to inquire routinely into clients' histories when content of initial assessments are prompted by use of an intake form specifically mentioning abuse experiences as demonstrated by Agar and colleagues (2002) in their New Zealand study. Perhaps unsurprisingly, when this intake procedure was used, there were increased disclosures of childhood abuse.

As already demonstrated, when mental health clients *do* disclose CSA, they do not necessarily receive help. Often, it can take a number of disclosures before the client receives a response that they find helpful (Frenken & van Stolk, 1990; Nelson & Phillips, 2001). It is for this reason that some researchers believe that all inquiries made by clinicians should be documented and all disclosures should be recorded in client case notes (Agar & Read, 2002).

The Status of Therapist Research into CSA Disclosure

The most popular methods used in gathering information about mental health professionals' experiences, views, beliefs and practices regarding CSA disclosure and inquiry have been questionnaires and surveys. These methods have allowed researchers to access high numbers of participants and data. It also affords the participant a level of anonymity in their responding. However, this risks a biased sample, as the professionals that *do* contribute, may have a vested interest in participating, unlike those who do not respond. Further, despite the relative anonymity of the method, social desirability of responding may have been a factor in responses (Frenken & van Stolk, 1990; Lab, *et al.*, 2000; Pruitt & Kappius, 1992; Young *et al.,* 2001). When studies employ forced choice options methods (tick-box or likert scales) this does not allow for the exploration of professionals' practice of inquiry or response; and their experiences of disclosure which may vary across contexts. Some limited use of qualitative interviewing was conducted within the Frenken and van Stolk (1990) study; however the data was presented with percentage frequencies rather than analysis following robust qualitative principles. Another qualitative study did involve therapists' discussion of CSA disclosure; however this was not the express focus of the research strategy (Chouliara *et al., under review*).

1.5: Clinical Psychology- A Changing Context

Following the introduction of clinically applied psychologists in the 1950s and the launch of training courses by Hans Eysenck and the Tavistock Clinic, the clinical psychology profession has continued to develop in terms of role and research (Pilgrim & Treacher, 1992). Half a century later, clinical psychologists are regarded as "scientist-practitioners" who carry out psychological therapy in addition to undertaking research, neuropsychological assessment, training and supervision (Huey & Britton, 2002).

Political contexts drive changes in structure and delivery of psychological services. There has been increased emphasis on preventative and Primary Care work. With the introduction of the Mental Health (Care and Treatment) Act for Scotland, referrals to psychiatrists have risen and much of their time has been directed towards mental health tribunals under the Act (Scottish Executive, 2003).

Delivering for Mental Health (Scottish Executive, 2006), the mental health delivery plan for Scotland sets out targets and commitments to help and improve the care and treatment of people with mental health problems. The key aims of the plan are to promote mental health and well-being; eliminate mental-health stigma and discrimination; prevent suicide and support those affected by suicide; and promote recovery from mental health problems.

Subsequently, mental health services such as psychology are encountering cases with increasingly complex presenting problems. The demands on psychological services have increased; the resources afforded to these services have not. Services are trying to reduce waiting lists and increase access to psychological therapy with limited resources.

This has also prompted developments in the way in which clinically applied psychologists are trained. Traditionally, clinical psychology training is undertaken within a three year taught doctoral programme, following an undergraduate degree in psychology. In response to the increased demand for psychological therapies within the NHS, there have been two developments in the profession in Scotland. Firstly,

the introduction of specialist training in clinical psychology was established in 2003 by the East of Scotland Clinical Psychology Training Programme (University of Edinburgh). This involved an additional 1-2 years of training alongside core and elective placements, where the trainee would undertake a period of service-contribution in a specific 'specialism'. Secondly, the training courses for Clinical Associates in Applied Psychology were developed through collaboration with Stirling and Dundee Universities and The University of Edinburgh. One of these is a one-year taught MSc course in Psychological Therapies in Primary Care. Herman (1992) states that therapists are likely to encounter CSA disclosures in clinical practice. It is expected that psychologists in mental health services from all training routes will have at least some exposure to working with people who have experienced CSA and CSA disclosure.

Trauma-Informed Mental Health Services

Within the United States, there is increasing emphasis on *Trauma-Informed Care* (TIC). This concept refers to the:

> *"recognition of the pervasiveness of trauma and a commitment to identify and address it early, whenever possible. Trauma informed care also involves seeking to understand the connection between presenting symptoms and behaviours and the individual's past trauma history. As a practice and set of interventions, trauma informed care involves professional relationships and interventions that take into account the individual's trauma history as part of efforts to promote healing and growth"*
>
> (Hodas, 2004, pp 6-7)

Trauma informed care offers a new paradigm in organising mental health services where a comprehensive understanding of clients' life experiences allows symptoms to be conceptualised within the context of underlying trauma. In order to shift towards the TIC model, the way in which services are run and workforces are trained will require substantial redesign (Harris & Fallot, 2001). At present, Scottish services have not adopted the TIC model in any systematic way; however developments within clinical psychology service provision and Scottish Mental Health initiatives

have contributed to a move towards a more trauma-informed model and are discussed below.

1.6: National Strategy- Implications for Psychologists in Scotland

Responding to Survivors

CSA has been described as an international health crisis (Scottish Executive SLWG, 2005). Andrew *et al.* (2004) assert that CSA poses a potentially devastating effect on lifespan trajectory. Increased demands on mental health services including psychology will be foreseeable in addressing the severe symptoms of anxiety, depression and post-traumatic stress which are common amongst survivors. However, given the lack of recognition of links between psychological symptoms and the effects of sexual abuse in childhood, mental health services over-emphasise a symptom-focussed approach rather than helping survivors to explore their sexual abuse history, its impact and developing coping strategies (Evison, 2007). This has sparked a shift in the way in which mental health services work with survivors.

In 2001, a Scottish Executive cross-party group set up the Short Life Working Group (SLWG) combining multi-agency, non-statutory service and survivor representation to conduct a review of the literature to guide an improvement of Scottish services for those who had been affected by CSA. A 2005 report from the SLWG emphasised the need to improve routine data collection, training and education for workers at all levels across all disciplines and to improve co-ordinated care pathways (Scottish Executive SLWG, 2005). In 2005, a national strategy for Survivors of Sexual Abuse was launched called *Survivor Scotland*. The aim of this strategy was to improve care and support services for survivors of CSA, to enhance existing local services, support their co-ordination and promote good practice amongst staff. *Survivor Scotland* emphasised the importance that survivors place on their interactions with staff, regardless of professional status who offer secure and firm boundaries yet relate interpersonally with warmth and kindness. They also valued members of staff, who are informed about CSA and trauma, have "examined" their own issues around working with sexual abuse, listen and respect the views of survivors concerning their

own specific needs, and offer survivors a choice of services and sensitively manage client confidentially

In specific reference to the role of psychology in working with survivors:

> *"Psychological services should be responding explicitly to the needs of adult survivors... services need to consider CSA survivors at all levels of service provision"*
>
> (Scottish Executive SLWG, 2005, p.21)

Following a review of the National Strategy and the implications for psychologists working within Scotland, the Scottish Branch of the British Psychological Society established a working party with the aim of providing recommendations and suggesting implementations of relevant aspects of the strategy (Evison, 2007). Psychological services are fragmented and under increasing pressures to provide short term input to service-users. Such an ethos amongst services contributes to failures in providing long-term support and consistency of care for survivors and may be perceived by survivors as rejection or abandonment (Scottish Executive SLWG, 2005). Psychologists often work with individuals with the most "complex" difficulties and will continue to do so. However, as the roles undertaken by psychologists evolve, they are increasingly equipped to collaborate with members of statutory and non-statutory services and service-user groups. For example, to raise public awareness, improve data collection and dissemination, contribute to training involving CSA knowledge and skills to all staff, contribute to supervision and support for staff providing "talking therapy" to survivors, to develop research strategies which involve survivors, to contribute to the co-ordination of local services, to network within and across psychological specialties to develop good practice, and establish partnership working.

Chief Executive's Letter

In 2008, the Scottish Executive issued the Chief Executive's Letter (CEL- 41, Scottish Executive, 2008) outlining expectations for health boards within Scotland to develop a three-year action plan to address gender-based violence (GBV). The CEL defines gender-based violence as an *"umbrella term encompassing the spectrum of abuse aimed at individuals and groups based on their specific gender role in society"* (CEL, Scottish Executive, 2008, p.9). GBV is used to describe all forms of violence which affect females "disproportionately" however it is clearly acknowledged that males are also likely to be victims of GBV. This model views CSA as one of the many pervasive forms of gender-based violence and as such recommends the use of routine enquiry of all forms of GBV, including childhood sexual abuse in health services, with a particular awareness of the likelihood of multiple abuse histories within the lives of mental health service-users.

1.7: "Sad Stories" in Clinical Practice

Given the drive towards a greater awareness of trauma in Scottish psychological services, it is important to understand the experiences of those working within this context. The bulk of the research into the response of hearing trauma-related material from clients relates to concepts surrounding *secondary trauma* (Marriage & Marriage, 2005). The effects and consequences of trauma are not limited to the survivor, but have also been shown to influence those that help the survivor. Most recently the literature has demonstrated that therapists who work with traumatised individuals are also affected. These effects have been understood using overlapping concepts as counter-transference, vicarious traumatisation (VT), secondary traumatic stress (STS), and burnout.

Counter-transference

This is a psychodynamic concept that relates to the interpersonal experiences and the psychological defences of the therapist, who then interacts with a particular client.

These processes may be conscious or unconscious for the therapist. This concept has significant implications for the therapists' clinical practice where the clinicians need to be aware of these feelings which may affect formulation and therapy (Marriage & Marriage, 2005).

Burnout

Professional burnout has been conceptualised as a progressive drain of mental resources caused by chronic stress. Burnout is characterised by three symptoms: emotional exhaustion, depersonalisation of others, and reduced sense of personal accomplishment (Schaufeli *et al.*, 1993). Maslach *et al.* (2001) model the interactions of these cardinal features of burnout.

Emotional exhaustion is theorised to occur when the emotional demands of the work exceed the emotional resources required to remain responsive to needs of the people served by the worker. Emotional exhaustion prompts the individual to employ psychological strategies to distance themselves from these demands. Depersonalisation is a psychological strategy in which the individual detaches from a sense of their own identity and the identity of others. Cynicism is regarded by Maslach and her colleagues (2001) to be a function of depersonalisation. Depersonalisation is an attempt to distance oneself from the emotional demands of others by disengaging from the aspects which make individuals unique. Hence, *"their* [service-user's] *demands are more manageable when they are considered impersonal objects of one's work"* (p.403). The third aspect of burnout, a loss of personal accomplishment is hypothesised to result from the interaction of exhaustion and depersonalisation where one's efficacy is impeded by chronic exhaustion whilst bearing a sense of indifference to service-users. Other characteristics of burnout have been suggested as fatigue, apathy, depression, boredom, discouragement and a loss of compassion (McCann & Pearlman, 1990).

Compassion Fatigue

Previously termed *Secondary Traumatic Stress*, this concept refers to the emotional distress which is experienced as a response to exposure to a survivor's traumatic material, which is: *"a function of bearing witness to the suffering of others"* (Figley, 2002, p.3). Symptoms of compassion fatigue are akin to those of Post Traumatic Stress Disorder (PTSD) i.e. experiencing intrusive imagery, emotional numbing/ avoidance and persistent arousal (Figley, 2002). Compassion fatigue (CF) was initially seen to affect care-givers and loved-ones of the trauma survivor, however this term has been broadened to account for its presence amongst nurses and therapists (Salston & Figley, 2003). In cases of CF, therapists may begin to dream their client's dreams or experience intrusive imagery resembling the client's own trauma. Avoidance may involve active attempts to distance one from thoughts, feelings or behaviours that remind them of the traumatic event, or even the client. They may also experience distress or become hyper-reactive to reminders of that trauma.

The agent of CF, according to Figley is the level of passionate engagement which the individual holds for the traumatised individual in their care. This model implies that an individual may actually become traumatised by concern for another's suffering. It is hypothesised that the therapist may employ extreme psychological strategies to cope with the effects of compassion fatigue; over identification with their client or detachment (Figley, 2002; Marriage & Marriage, 2005).

Vicarious Traumatisation

Vicarious traumatisation (VT) is defined as a transformation of the inner experience of the therapist which occurs as a result of cumulative interactions between the client's traumatic material and the empathic engagement between client and therapist (Pearlman & McCann, 1995). This relates to permanent shifts in core beliefs including: trust, safety, control, esteem and intimacy (Pearlman & McCann, 1995). Intrusive imagery, dissociation, increased emotional avoidance, anxiety and other

trauma symptoms have been associated with vicarious traumatisation (McCann & Pearlman, 1990).

To further conceptualise vicarious traumatisation, McCann and Pearlman (1990) developed Constructivist Self-Development Theory as a framework to account for the VT model. This combines developmental, interpersonal and cognitive theories. Cognitive schemata (mental structures for understanding the world and one's experiences) are implicated in a complex interaction with the trauma survivors and their narratives. This model holds that schemata become distorted, shifting the 'lens' with which the individual sees themselves and the world. The schemas which are hypothesised to be involved are those of: safety (from harm to self or others), trust/dependency (the ability to trust oneself and others), esteem (to feel of value and that they are valued by others and in turn that they have the ability to value others), control (the capacity to manage one's own feelings and behaviours and to be able to manage those of others), and intimacy (a sense of interpersonal connection).

While such concepts as Secondary Trauma and Burnout being accepted clinically, the research base has been criticised due to inconsistency with which these concepts are operationalised (Chouliara *et al.,* 2009). Elements of each have apparent similarities. For instance, the depersonalisation symptom from burnout may mirror detachment, which a therapist employs in their attempt to cope with the effects of compassion fatigue. A sense of disconnection from others may also represent a disruption to a therapist's intimacy schema in the case of vicarious traumatisation.

Despite similarities, the fundamental concepts of each differ. Burnout is a reaction to chronic work-related stress and is mediated primarily by the occupational environment (Maslach *et al.,* 2001). Compassion fatigue refers to a sudden onset of trauma symptoms which occurs within the context of 'single-doses' of contact with a primarily traumatised individual with whom they have a caring relationship (Figley, 2002). The conceptualisation of vicarious trauma however, focuses less on symptoms, more on the gradual yet profound cognitive shifts which occur following

the cumulative effects of working with traumatised people (McCann & Pearlman, 1990).

Therapist Defences

The concept of psychological defence originates from psychodynamic theory and refers to:

> *"a protective mental activity that mediates the individual's needs and external reality...[and]... operate in response to internal and external stressors, without conscious effort, and follow specific patterns"*
>
> (Despland, Bernard *et al.*, 2009, p.74)

Unconscious defence mechanisms:

> *"may influence therapists' coping strategies because workers who are uncomfortable in the presence of powerful emotions, or whose affect tolerance is exceeded, will draw upon familiar, protective defences"*
>
> (Adams & Riggs, 2008, p.2)

Herman (1992) suggested that defences which involve avoidance (e.g., denial, dissociation, numbing) and overbearing care-giving are commonly used by therapists in response to vicarious traumatisation. Avoidant defences may result in minimization of the client's traumatic narrative, discouraging the client from discussing certain issues or even distancing them self from the client's distress by referring the client onto other services. Equally, a therapist may become *over-involved* and intrusive towards the client and their traumatic material, may act impulsively, violate boundaries and make attempts to rescue or control the client (Adams & Riggs, 2008).

Adams and Riggs (2008) conducted an exploratory study with 54 therapists in training. Those who indicated an adaptive defence style (suppression, sublimation, and humour) reported low levels of vicarious traumatisation. However, almost 50 per cent of trainees reported a self-sacrificing defence style, which was associated with significantly greater trauma symptoms.

Pearlman and McCann (1995) studied therapists' trauma beliefs. Therapists with the least experience of working with trauma survivors, a personal history of trauma and therapists who were not receiving regular supervision showed the most psychological difficulties. Those with greater experience of working with survivors and who had received ongoing training in working with survivors, showed less psychological difficulties. Similarly, Adams and Riggs (2008) found that trauma training was a protective factor against vicarious traumatisation.

Vicarious Traumatisation and Coping

Harrison and Westwood (2009) conducted a qualitative study with mental health professionals. Participants were asked how they manage personal and professional wellbeing when working with traumatised clients. Protective practices were identified as managing professional, personal and spiritual isolation; consciously expanding perspective to embrace complexity; active optimism; holistic approach to self-care; empathic 'attunement' while maintaining clear boundaries; professional satisfaction and therapists' ability to find meaning in their work. The instruments used to achieve protective practice included supervision, training, professional development, organisational support, undertaking diverse roles (such as teaching and supervision), meditation and physical exercise.

In examining the literature into clinician's experiences of trauma narratives, there is an emphasis on concepts relating to the harmful effects of working with abuse survivors. This is illustrated by one study where researchers emphasise the occupational hazard of working within this field which has *"devoted increasing attention to the potentially harmful impact of working closely with traumatized [sic] individuals"* (Adams & Riggs, 2008, p.26). As yet, the empirical concern appears to focus on the harm of hearing difficult information within clinical practice, while there appears to be limited research exploring the effects of experiencing abuse narratives and disclosures which are benign or even positive for the clinician.

1.8: Summary and Rationale for Research

The disclosure of CSA histories by adult clients in therapy is a clinical reality for many therapists (Herman, 1992). Psychologists working within mental health find themselves increasingly working with clients who have a history of CSA. Recent publications have strongly advocated the routine practice of asking mental health service-users about abuse and emphasised the importance of working towards psychological formulations which can take into account the presence of childhood sexual trauma (Read *et al.,* 2007; Scottish Executive, 2008). However, professionals' responses to CSA disclosures have been mixed, so too has the practice of inquiry (Agar *et al.,* 2002; Young *et al.,* 2001). Furthermore, inquiry and hearing disclosures of CSA can be a complex experience for both client and therapist. Given the importance of establishing sexual abuse histories of clients within trauma-informed services, particularly within psychology, it is important to consider the experience of disclosure further.

There have been a small number of studies which have offered an in-depth account of survivors' experiences. This has ranged from survivors' experiences of disclosure to their experiences in accessing services. To date, the bulk of the research into the therapists' experience of disclosure has been derived from survey or questionnaire-driven designs. The foci of these studies have included providing an estimate of mental health professionals' knowledge and training in sexual abuse issues, rates of inquiry and disclosure from clients and lists of factors which are believed to be barriers to effective inquiry. Furthermore, this research has concentrated on clinician practices and experience rather than aiming to derive a theoretical account of experiencing disclosure.

Current theory of the impact of working with survivors of trauma such as CSA remains established in concepts relating to secondary trauma. As yet, there is a lack of scientific research that takes into account the psychologist's experience of CSA inquiry and disclosure. This project aims to derive descriptive, qualitative data from semi-structured conversations with psychologists which will inform a theoretical construction of the phenomena. A Grounded Theory of psychologists' experiences of CSA disclosure is expected to provide a foundation for subsequent methodological

research into the area. Further, the findings of this research are expected to have practice implications for the psychologist, and repercussions for the client and their wider system of care. This may better equip us to support clients and psychologists. The findings of this study may also help facilitate further understanding in what constitutes good-practice and how this may inform training, service-development and supervision.

2: Method

Qualitative methods are being used increasingly in the field of psychological research. This chapter outlines the use of Constructivist Grounded Theory in this study. The design used established research methods of constant comparison, theoretical sampling and sampling to saturation in order to ensure rigour and quality. These features of the research design are described below. In the second section of this chapter, the procedure is detailed to provide a coherent and transparent account of the steps undertaken in this study.

2.1 Design

In designing this study, a number of issues were implicated in the suitability of a qualitative research paradigm rather than a quantitative approach. This section presents the rationale for design and describes the methodology of this study.

Qualitative research is "concerned with the discovery of *substantive theory*" (Glaser & Strauss, 1970, p.289). The use of qualitative methods has become increasingly commonplace in psychological research. Their use has been strongly recommended in fields of research where the aim is to explore human experience and to elaborate understanding in areas where little is known or to yield a different understanding of a well-researched area (Strauss & Corbin, 1990).

In qualitative research, the role of the researcher is central. Creswell (2003) describes the qualitative researcher as the primary instrument in data-gathering. The researcher uses interactive methods of data collection, and then interprets findings within personal, social, cultural and historical contexts (Creswell, 2003). The research process is iterative in nature and the researcher refines inquiry in the face of emerging data (Creswell, 2003).

This study could have adopted any one of a number of qualitative methodologies, such as ethnographic, phenomenological, narrative, heuristic, discourse analysis and

grounded theory. Grounded Theory (GT) was chosen as the most appropriate method for this study for two reasons. Firstly, GT offers the researcher scope to generate categories and hypotheses that are clear enough to be readily implemented in both qualitative and quantitative approaches (Glaser & Strauss, 1967). As such, the conceptualisation of psychologist's experiences of disclosure may have implications in further research and clinical practice, rendering it an appealing option for a research-practitioner.

Secondly, as my role of research 'instrument' would occur within my own profession, this study required a methodology that could offer a means of managing my own experiences and pre-conceived notions of issues relating to disclosure in clinical practice. Researcher bias has been seen as a 'limitation' in quantitative research methods (Banister *et al.,* 1994). However, qualitative researchers acknowledge that research data is rooted in the circumstances from which they were generated (Strauss & Corbin, 1990). The subjectivity of the researcher is taken seriously and examined using processes of reflexivity that make this subjectivity transparent in the research. As such, the researcher does not seek to *eliminate* their own prior personal and theoretical subjectivity; instead the researcher reflects and accounts for bias as part of data analysis (Charmaz, 2006; Strauss & Corbin, 1990). Grounded Theory offers a set of principles to allow the researcher to present a transparent account of their decision-making within data analysis and the credibility of the findings (Strauss & Corbin 1990). This allowed my decisions to remain close to the data, by starting at concrete descriptive analysis and only then moving towards more abstract levels of analysis.

The Development of Grounded Theory

Grounded Theory was developed as a method of inductive analysis by Glaser and Strauss in 1967 (Charmaz, 2006; Glaser & Strauss, 1967; Strauss & Corbin, 1990). GT involves constant comparison of the data and theoretical sampling to ensure a systematic and rigorous strategy of deriving theory from data. Rather than generating theories in the abstract, they remain 'grounded' in and faithful to the data. This

enables the development of a 'middle-range' theory which encompasses the individual and the social context as opposed to local theory and grand theory (Glaser & Strauss, 1967).

Constructivist Grounded Theory

Constructivist Grounded Theory (CGT) evolved from the traditional GT method (Charmaz, 2006). Charmaz felt that Glaser's view, that data could be 'discovered' to establish a 'generalisable' truth for all, supported a positivist philosophy and did not fully account for the role of the researcher and participant (Charmaz, 2006). The Social Constructionist philosophy asserts that human behaviour conveys meaning which is influenced by language, social norms, motives, beliefs, socio-cultural and historical factors. If 'reality' is influenced by these contextual factors, then it may be one of multiple realities (Charmaz, 2006). Social Constructionists theorise that "all forms of knowledge, including *scientific* knowledge, produce images of the world that then operate as if they were true. This does not mean that social constructionists are necessarily opposed to 'science'... [but see science]... as a form of knowledge which creates as well as describes the world" (Banister *et al.*, 1994; p.9).

CGT holds central to its model the relationship between participant and researcher which contributes to the construction of a shared reality (Charmaz, 2006). Hence, the research relationship holds a vital source of knowledge which is: *"not something objective and removed from our bodies, experiences and emotions but is created through our experiences of the world as a sensuous and affective activity"* (Hubbard *et al.*, 2001, p.126). It is through our emotional experiences that we make meaning and interact with the physical, natural and social worlds in which we dwell. Therefore, the role of emotion in the research relationship is an essential part of qualitative research, where the emotional experiences of the participants and researcher offer unique and valuable data to be analysed.

Theoretical Sampling

In contrast to sampling methods used in quantitative research, the purpose in CGT is not to arrive at generalisable 'rules' for behaviour by establishing frequency or distribution of the phenomena studied. Theoretical sampling is a process of participant selection in which fresh observations are pursued to investigate their analytical relevance. Theoretical sampling is used to enhance developing theory and is be adapted throughout the data gathering process. As the researcher analyses the data, they often find out that they need to sample more data to sufficiently explore a particular emergent theoretical category (Charmaz, 2006). As theoretical categories are constructed during analysis, the researcher does not know what they will be sampling from the outset (Strauss & Corbin, 1998). Thus, theoretical sampling is a flexible process where the resulting data and categories dictate the choice of participants. Further, the researcher can ensure that key lines of inquiry are adequately followed, key issues that arise are sufficiently represented and that constructed theory remains grounded in the data (Charmaz, 2006). The purpose of sampling was not to test hypotheses and arrive at an empirical generalisation. Rather, I wished to select participants who demonstrated the best likelihood of exploring and elaborating on codes and categories within the data which relate to the clinical experience of CSA disclosure.

Constant Comparison

The researcher undertakes a process of subjecting the data to constant comparison. This involves observing similarities and differences within the data at each analytical level. For example, initial codes were compared across interviews, within the same interview, and against codes relating to the theoretical literature. Previously coded data was checked against new codes for relevance. This process aided in testing out emerging ideas, allowing research to follow emerging directions and to let open codes which did not fit into emerging categories fall by the wayside (Charmaz, 2006). To facilitate scrutiny of coding, open codes were discussed in research supervision.

Saturation and Sufficiency

When purposive sampling is used in order to gain maximum variation amongst participants, the researcher must be able to know when they have interviewed enough participants. What constitutes 'enough' in qualitative research requires the researcher to demonstrate that they have considered two issues: theoretical saturation and sufficiency. The concept of data saturation is the point where emergence of new theoretical categories ceases and there is no more variance amongst existing categories. This means that the interviewer is no longer hearing or learning anything new and the same information keeps coming up. This marks the end point of data collection and analysis (Strauss & Corbin, 1990). In considering the second, the researcher must demonstrate that they have obtained sufficient numbers to reflect the range of participants which constitute the population studied so that the results have some resonance for those out with the sample (Seidman, 2006). This study required enough participants to reflect psychologists' experiences of CSA disclosure from clients; requiring men, women and a range of length of qualified practice.

Negative Cases

This aspect of analysis requires the researcher to look for negative cases within the data (i.e. cases that do not fit within categories) (Lincoln & Guba, 1985). This is a means of informing theoretical sampling and of ensuring that all efforts have been made to exhaust the emergence of categories and achieve data saturation.

Coding and Category Construction

Grounded Theory is an iterative approach to data gathering. With GT, initial interviews are analysed through coding. The resulting codes from this process then inform the evolution of the interview guide in subsequent interviews. Throughout this process, the researcher will 'test out' existing codes, construct new codes and

discard redundant codes depending on what emerges in the narratives of participants. Codes are fuelled or die out on the basis of importance. 'Importance' does not necessarily denote the frequency with which a particular code emerges within the data. What determines the importance of a code, and the emerging theoretical concept is rooted in how much it resonates with the researcher and how grounded it remains in the data, what the participants say (or do not), how they respond to certain lines of inquiry and how the researcher reacts to the participants' narratives. It is for this reason that the use of a research journal and memo-writing are necessary strategies to examine the researcher's decision-making throughout this process. As the emergent theory follows a 'bottom-up process', the construction of categories can be traced back to the earliest stage of coding, thus theoretical categories remain grounded in the participants' narratives.

2.2: Procedure

2.2.1: Participants

Eight psychologists took part in this study. Participants were between four and thirty-five years qualified, with a range of two and thirty-five years of clinical practice post-qualification. Two participants were male and six female. The sample consisted of seven clinical psychologists and one clinical associate in applied psychology. Working contexts within Adult Mental Health (AMH) were: primary care, primary and secondary care and specialist services. One psychologist worked in primary care, three worked across primary and secondary care specialities, two worked exclusively in secondary care and two worked in specialist eating disorders and psychosis services.

Inclusion Criteria

Psychologists were included to reflect the aims of this study; an investigation of the experiences of disclosure of childhood sexual abuse in AMH clinical psychology

practice. As such, the inclusion criterion of this study was that participants were employed and practiced as psychologists within the National Health Service (NHS) and within the adult mental health sector. This author acknowledges that psychologists who work with all ages of client are likely to encounter disclosures of CSA; however to establish sufficient focus, this study investigated the experiences of AMH clinicians who had experienced CSA disclosure from a client (or clients) within the last six months of practice. Participants were included if they had two or more years of qualification to ensure the likelihood of experiencing CSA disclosures, however it is well appreciated that clinicians at all stages of training are likely to experience disclosure from clients.

Recruitment

Participants were recruited from one clinical psychology department in the East of Scotland. This is one of the largest area departments in the United Kingdom and it was felt that this would offer a good potential sample of psychologists working in AMH who had experienced CSA disclosure. Head of Service Locality permission was granted to attend team meetings in all bar one of the locality teams to explain the rationale for this research. Detailed information sheets were issued to every psychologist who met the inclusion criteria for this study to invite participation (appendix 1). Two individuals volunteered to act as independent contacts located within Edinburgh University Clinical Psychology Training Programme and NHS health board Psychology department for potential participants to contact with any queries or concerns regarding the project. Potential participants were given consent forms (appendix 2) which were designed to ensure that each statement was read carefully before responding by creating multiple responses to be initialled by the psychologist. They were given three weeks to decide on their participation in this study and non-responders were not followed up.

2.2.2: Ethics, Reliability and Validity

Ethical Issues

Ethical approval was sought from two committees. The University of Edinburgh Clinical Psychology Ethics Committee were satisfied with the design, methodology, validity and potential importance of the proposed study (appendix 3). Although potential participants were psychologists and able to provide informed consent, their status as employees of the NHS was taken into account prior to recruitment. Therefore, ethical approval was sought from the local NHS research ethics committee and received a favourable opinion (appendix 4). Following this, NHS management approval was provided (appendix 5).

The ethical framework for protecting participants in qualitative research rests on autonomy, beneficence and justice. Consideration of these issues in planning this study is outlined below.

Autonomy

Autonomy, according to Orb *et al.* (2000) refers to the principle that the values and decisions of all potential participants are respected in recruitment and commission of research. This principle was followed by ensuring the informed consent of participants. Participants were informed that the objective of this research was to explore psychologists' experiences of CSA disclosure in AMH.

Beneficence

This principle refers to the responsibility of research and researcher to minimise the risk of harm and to ensure that benefits of carrying out the research outweigh the potential costs (Orb et al. 2000). Given the consistent evidence that CSA is prevalent throughout all sections of society and culture, it was reasonable to expect that

psychologists themselves may have been survivors of abuse. Furthermore, CSA is a sensitive topic so it was made clear that to minimise participant distress, discussion of personal history would not be required for participation. To ensure strict participant confidentiality, all transcripts of interviews were anonymised (including personal identifiers such as gender, etc) and actual digital recordings of interviews were deleted once they had been transcribed.

Risk of harm was not only considered from a participant perspective, but also from the perspective of the wider public. It was emphasised in the participant information that any information that lead to child protection concerns would be followed up through appropriate child protection channels. It was also stressed that any discussion of behaviour from psychologists that was in breach of British Psychological Society (BPS) *Guidelines for Professional Practice* (BPS, 1995) would be discussed with the researcher's clinical supervisor and participant's line manager.

Psychologists are not unfamiliar with the benefits of participating in research and information provided to potential participants detailed the potential value of this research study for clinical practice.

Justice

This principle stipulates that all participants are equal, should be treated with fairness without exploiting their position (Orb *et al.*, 2000). As part of protocol, this research was discussed with the Head of Psychology Service for permission to undertake research within this service. Regardless of permission, it was emphasised to participants that they were under no departmental obligation to participate in this study, the decision to participate was left with the psychologist.

Justice also refers to the researcher's recognition of the participant's vulnerability and their contribution to the research. Participation in qualitative research is often more time consuming and personal for the participant. Given the nature of the

information freely offered by psychologists in this study, I was keen to discuss with them any information revealed in interviews that may be personally 'exposing' to them, where they were given the opportunity to remove if they wished. One psychologist requested this.

Research Context

In considering the ethics of research, the context of research must be taken into account in order to understand potential researcher-participant dynamics of power and to inform the researcher about this in data analysis (Charmaz, 2006; Orb *et al.,* 2000). In this section, the organisational structure from which participants were recruited and some background information about the researcher is outlined in order to clarify the context in which the data was collected and analysed as well as the 'lens' through which it was examined and interpreted.

Researcher Context

I am a Specialist Psychological Practitioner, which is the official job title of a Specialist Trainee Clinical Psychologist within 4th and 5th year of training. I have worked in this department for seven years from pre-doctoral training as an assistant psychologist and then doctoral training within Secondary Care Adult Mental Health 'specialism'. I have known many of the participants for a number of years in a professional capacity and have a fond regard for many of my colleagues.

As a clinician, I have experienced the disclosure of childhood sexual abuse from a number of clients throughout the years. My research and clinical interests focus on *complex trauma*, attachment and personality, and psychotherapeutic models which are in no way exclusive to (although often concern the sequelae of) CSA. Theoretically, I have been most influenced by Cognitive and Humanist therapies such as Schema Therapy, CBT and Sensorimotor Psychotherapy.

I have experienced CSA disclosures from personal friends and have experienced disclosing material of my own history of childhood sexual abuse. I have experienced a range of responses to disclosure. I am accepting of my status of abuse 'survivor' although I rarely use this term with regard to myself. Many people within my personal relationships are aware that I was sexually abused in childhood.

I have routinely engaged in personal therapy to help me in my clinical practice to highlight 'blind spots'. I have experienced a number of attitudes from professionals within mental health services regarding survivor-therapists, some of these comments were critical of any survivor's ability to work therapeutically with other survivors.

I do not routinely disclose my survivor status to colleagues, although I have to some. Within my professional work, I am aware of my own personal history and how this may impact on my work. I do not feel that my history precludes me from clinical or research activity concerning childhood sexual abuse however I do believe that it is important that I remain open and aware of potential countertransference and the impact that this may have on my work.

Participant Context

This NHS Psychology Department consists of four locality teams providing psychological input to adults (aged 16-65) within the East of Scotland. Department statistics for 2009/10 revealed that the AMH team see 3306 people per year. There are a total of 32.4[3] clinicians working in either full time or part time posts. The AMH service provides a wide range of specialist services ranging from Primary Care, Secondary Care and Tertiary Care; these include Addictions, Severe and Enduring Mental Health and Anorexia Nervosa Intensive Treatment Team.

Within the United Kingdom, entry to train as a clinical psychologist requires an undergraduate degree in psychology. Training places are funded by the NHS and

[3] Whole time equivalent

master and doctoral level training is provided by universities throughout the UK, involving practical and academic training, research projects and clinical placements (Clearing House for Postgraduate Courses in Clinical Psychology, 2010).

2.2.3: Data Collection and Analysis

Interviews

Face-to-face interviews were identified as the most effective means of offering an in-depth exploration of the experiences and conceptualisations of psychologists regarding CSA disclosure. Semi-structured interviews were used to allow me to engage with participants in a flexible and evolving discussion whilst being able to address the range of topics during the interview (Charmaz, 2006).

Prior to data collection, a draft interview guide was constructed (figure 1). Pilot interviews were conducted with two trainee clinical psychologists and one clinical psychologist; this enabled me to develop my interview style and to refine questions and prompts.

The interviews were guided by a list of topics which were to be covered in each interview session. As the programme of interviews progressed, participants raised additional issues, which then went on to form an integral part of this study's findings. The discursive nature of the interviews allowed iterative refinement and lines of thought identified within earlier interviews to be picked up and presented in subsequent interviews. This style of interviewing permitted me to ask specific questions yet provided enough flexibility to clarify statements than would be afforded by a rigid interview schedule (Bryman, 2004).

Figure 1. Interview Guide

Can you take 5 minutes to think about a client that you have seen who has had a history of CSA?

- What things come to mind when you are thinking about this client?

- How does it feel to think about this client?

- How did the CSA history emerge?

- How does this experience compare with your experience of working with other CSA survivors?

- How does this experience compare with your experience of working with other clients?

What do you think is being communicated in a disclosure?
What do you think is being communicated by asking a client about abuse?

- Is this something that is explicit?

- How do you think this influences your clinical practice?

What do you think is important for you as a psychologist to be able to see people who disclose CSA histories?

- How does this differ from your work with people who are not survivors of CSA?

- What training/ practical work experiences help develop your practice?

- What are the challenges/ difficulties in this work?

All participants were asked to think about a specific client that had a history of CSA. This was used to set the scene for the participants and to elicit the emotional material connected with participant's experience of CSA disclosures which offered a rich source of data.

In accordance with the constant comparative method, inherent in GT, interviews and data analysis were conducted in parallel (Charmaz, 2006; Strauss & Corbin, 1998). As data collection progressed, and previous interviews had been analysed, this allowed me to focus and investigate lines of enquiry that had emerged previously. However, theory verification was kept (as much as possible) to the later parts of interviews in order not to stifle other data that would emerge from the interview being allowed to run its course.

Interview Procedure

Participants were interviewed within department bases. Although participants were given the option to be interviewed at an alternative location to suit their time, no one chose to do this. This meant that participants were all interviewed within their 'natural' professional setting (Charmaz, 2006). Once participants gave their permission, they were contacted to arrange an interview at a time of their convenience. Data was collected until the point of data saturation was believed to occur.

At the start of each interview, participants were reminded of the 'anonymisation' process that would be undertaken with all data. As mentioned previously, all participants were given the opportunity to read through the typed transcript of their interview to check for accuracy.

Data Management

Interviews were digitally audio recorded and transferred to digital files. Interviews were transcribed verbatim and then digital recordings were destroyed. On completion, transcripts were imported into the data management software: NVivo 8 (QSR International, 2009-2010). This functioned as a data management tool which allowed quick and systematic organisation of codes. The use of computer software in qualitative research has been advocated as a means of quality assurance and ensuring rigour (Bazeley, 2007).

Data Analysis

This section will outline the core strategies from Constructivist Grounded Theory that were used in data analysis.

Coding

Data was analysed in accordance to principles of Constructivist Grounded Theory, incorporating initial exploratory coding, followed by the stages of interpretative coding (Holton, 2007; Charmaz 2006). Coding is described by Charmaz as providing the "*bones of analysis*" (Charmaz, 2006, p.45). Data analysis occurs at two levels: open coding and focused coding (Charmaz, 2006). At the initial stage, the researcher describes the content of the text using descriptive codes. This can be done in a number of ways such as coding the data word-by-word or line-by-line. The purpose in the initial stage of coding is to remain as open as possible to all theoretical directions of the data (Charmaz, 2006).

In this study, line-by-line coding was used as it seemed the most appropriate means of retaining the descriptive value of the data, which may have been lost through, for example word-by-word coding. This approach is intended to keep the researcher close to the data while forcing them to be analytical. This strategy reduces the influence of the researcher's pre-analytic assumptions on their analysis. Strauss and Corbin (1990) remind researchers to ask what is happening and what each statement represents when examining the data for initial codes. Wording is important in coding; the use of gerunds is seen as preferable to nouns (Glaser, 2001). This is termed *"action coding"* and is an effective means of keeping the researcher at the initial stage of analytical work rather than making premature *"conceptual leaps"* to abstract levels of theory (Charmaz, 2006, p.48).

Following initial descriptive coding, codes are refined into focused coding. Focused coding is used to synthesise large sections of initial codes. According to their importance and patterns, codes are linked together (Glaser, 2001). At this stage, the researcher seeks to establish an emerging set of categories that can be used to create a conceptual understanding of the data and can contribute to the generation of theory.

Examples of line-by-line coding and subsequent focussed coding are provided using an excerpt from an interview with Participant 4 (figure 2).

Figure 2. Example of Initial Line-by-Line and Focussed Coding

Interview transcript	Line-by-line Coding	Focused Coding
I mean, I'm talking about the human side of that, but you also need to be keeping in mind things like psychological theories, like the fact that exposure helps people get over these things and it's combining human element, human side of you, that empathic element with the, I suppose, I don't want to use the word "technical" but, the kind of techniques, I suppose, the theory behind what you're doing, you should have a rationale for what you're actually doing, you're not just developing a relationship with someone in the normal sense of the word, you're helping them recover from something, so you do need all your other psychological techniques and ways of formulating the problem to drive what you're doing. I suppose the difference being, is that you're using more of yourself with this client group [...] and you're also going to take them into a space of stress so you need to be able to, I suppose, become comfortable with where you're going to be taking that person, and they need to trust you to know that you have a good rationale for that and they can go places that are painful and that you have hopes that they will feel better as a result of it.	Balancing the human part of me with the psychological skills Using exposure therapy with human empathy Needing a rationale for what I do Using the relationship therapeutically Helping the client recover from abuse with psychological skills and techniques Using more of myself with survivor clients Needing to be comfortable with the stress of the work	Giving more of myself Using formulation Demonstrating competency

Theoretical coding allowed for the construction of core concepts and categories and this is detailed in Chapter 3. Coding underwent a process of repeated abstraction until relevant codes could be represented within categories in the most parsimonious manner. In some instances, codes which were initially positioned in one category, contributed to the construction of another and were subsequently repositioned. For example, in constructing the sub-category "pacing disclosure" (section 3.1.1.1) initial codes which contributed to this were: "managing chaos", "stabilising the client", "holding the client's emotions" and "following emergence". As the coding process progressed, the codes relating to holding and containment of the client's emotions

were separated and contributed to the subcategory "containing the relationship" (section 3.1.2.1)

Memos

Memo writing refers to the process of recording the researcher's thoughts, ideas and decision-making as they evolve throughout the study. Charmaz (2006) affords this process a special importance. Charmaz differentiates between two methods of memo-writing: ''early memos'', which record what is occurring in the data, flesh-out codes and direct further lines of investigation and ''advanced memos'', which are used in describing how categories emerge and in making comparisons (Charmaz, 2006). Memos were kept as thoughts or notes to myself and took the form of both hand-written notes and typed notes within the NVivo 8 programme. An example is provided in figure 3.

Figure 3. Example of Early and Advanced Memos

Early Memo: **Balancing Engagement with the Client** *This seems to be a 'balancing act'. P1 [Participant 1] talks about needing to be emotionally engaged and "in the room" to be able to hear and work with disclosures but then also talks about "man's inhumanity to man" and other distressing costs to having an empathic engagement with a client and their abuse history.* *How do psychologists feel about this? And what are the consequences to keeping or losing this balance?*
Advanced Memo: **Maintaining Accurate Empathy** *P7 [Participant 7] describes 'accurate empathy'. This subsumes the previous notion of "balancing engagement". Accurate empathy is a process of engagement with the client and their abuse disclosure. Too little empathy, and you run the risk of insensitivity or being unable to understand the client (and demonstrate that to them). As P7 joked: "it's better to show some empathy than none!" Too much empathy (which P7 links to "our own stuff") is when one is overly drawn into the client's abuse. E.g., "that's awful, that's terrible, oh my god!, etc".* *This links to what P5 described as an insensitivity that may creep in as the psychologist becomes desensitised to hearing disclosures of CSA. Empathy, then may change over time requiring the 'empathizer' to keep a balanced sense of empathy, remaining in tune and sensitive to that specific client in front of them.* *This is a skill- and a pre-requisite? to being able to hear disclosure.*

This seems to link with concepts from the Burnout literature, where depersonalisation occurs as a means of distancing oneself from the emotional demands of the therapeutic work. Insensitivity or detachment may be manifestations of depersonalisation- is this what the psychologists are warning me about? According to the literature, engagement is the "antithesis" of depersonalisation- this seems to be another function of maintaining accurate empathy.

This seems also to link with the VT [Vicarious Trauma] *literature* [where] *repeated exposure to traumatic material causes profound schema shifts. A failure to use accurate empathy may be a result of the psychologist's disconnection (intimacy schema).*

[Note: "Maintaining Accurate Empathy" later became subsumed under "Demonstrating Competency", which is a sub-category of "Nurturing the Pre-conditions to Disclosure"]

Clustering

Clustering was used to aid memo writing (Charmaz, 2006). Clustering is a visual and non-linear approach that allowed the researcher to explore how the focussed codes related to each other. Diagrams were used to help cluster and map out categories. An example of this can be found in (appendix 6).

Transcription

Direct quotes are used to illustrate concepts and to evidence the development of codes and categories. References to participants within this chapter will be made using female pronouns; this reflects the overrepresentation of females within the profession and is used to preserve the anonymity of the small number of male participants who could be identified. Further, in the instances where participants gave examples from specific cases, the client will also be referred to as female to preserve anonymity and reflect the high proportion of adult females who are CSA survivors.

Transcribed dialogue is presented in *italics* and for the purposes of clarity, the researcher's speech is presented in the text in ***bold*** type. Brief remarks interjecting into the dialogue of the primary speaker is in parentheses e.g. (*uh huh*). Short pauses are indicated by a comma, longer pauses are indicated with ellipsis (e.g. ...) and a longer pause is indicated by a full stop. Where sections of text have been truncated, this is denoted by ellipsis enclosed in square brackets e.g. [...] within the text.

Non lexical communication such as laughter is indicated in within square brackets e.g. [*laughs*]. At points where data has been anonymised, information is presented in square parentheses e.g. [name]. To demonstrate emphasis in speech, this is denoted by underlining, e.g.: "it has... it can have an effect". This transcribing system was developed by the researcher following principles of transcription employed by Jefferson (2004)[4].

Quality Assurance in Qualitative Research

The positivistic standards applied in quantitative paradigms (validity, reliability and 'generalisability') have been revised in favour of standards more fitting to qualitative research. Criteria have been developed for evaluating the methodological and analytical rigour of qualitative research. In the post-positivistic qualitative research paradigm, the term "trustworthiness" applies to the reliability and validity of the study which need to be demonstrated by the researcher for the reader to have confidence in its findings (Lincoln & Guba, 1985). Yardley's (2000) framework for quality assurance in qualitative research presents the criteria of: sensitivity to context, commitment and rigour, transparency and coherence and impact and importance. This framework was used to ensure the trustworthiness of this study.

Sensitivity to Context of the Research

Yardley (2000) states that quality is established in qualitative research through the researcher's sensitivity to the context in which the study is carried out. There are a number of ways that this can be demonstrated.

[4] Jefferson's chapter details her transcription system in Conversation Analysis (CA). CA is qualitative methodology which is concerned with the study of social knowledge through a fine-grained analysis of language. CA is not concerned with either context or motive unless it is explicitly included in the conversation. Transcription within the current research study was modified accordingly to reflect participants' narratives without requiring such a fine-grained analysis of language.

Theoretical Context

In planning this study, I have investigated the theoretical and evidence base surrounding CSA disclosure and response. Such a knowledge and understanding of the relevant literature is vital in a sophisticated interpretation of the data. However, Yardley (2000) asserts the importance of grounding the emerging theory within the data whilst pursuing lines of investigation that may contradict the researcher's theoretical understanding, examining the resultant data and accounting for the disparity. In the Introduction chapter, the theoretical context is introduced, with reference to the relevant literature and empirical data. The interpretations made in the research process remain grounded in the data and this is evidenced by including transcripts of the raw data when describing theory and concept. In order to develop interpretation, I have actively sought out experiences and attitudes that contradict what has already been revealed by participants. To further develop interpretation of data, I have also discussed emerging concepts to participants for clarification and sought their opinion about what meaning they derive from the information and compared it to my own interpretations of the data.

Socio-cultural Context

Given that society and culture are major influences on meaning; researchers need to demonstrate an awareness of the "*normative, ideological, historical, linguistic and socioeconomic influences*" on the experiences and attitudes of not only the participants but the researcher too (Yardley, 2000, p.220). In addition to training experience (discussed in section 2.1) other influences on the psychology profession were considered to be: increasingly high numbers of referrals to psychology services, pressure to reduce waiting times, and emphasis to provide a limited number of sessions whilst remaining responsive to targets to address the impact of CSA in adulthood (including mental health problems). Current theoretical discourse within clinical psychology also involves the adherence to models of 'here and now' focussed work versus the exploration of a client's historical factors and how they interact with theoretical perspectives. For example, learning theories and Rational

Emotive Behaviour models of therapy may place a greater emphasis on working within the present (e.g. changing current behaviours and beliefs) whereas other psychological models such as Cognitive-behavioural, Schema Therapy, and Psychodynamic therapy may place differing levels of emphasis on childhood experiences in formulation and therapy. It is important to consider the impact of these socio-cultural contexts on psychologists' experiences of CSA disclosure.

Participants' Perspectives

The researcher must consider the relationship between the researcher and participants and what specific characteristics of the researcher (i.e. gender or status) may have influenced the data. As a researcher with pre-existing relationships to the participants, it was possible that my multiple roles were a disadvantage within this study and this is considered here:

Given my position as a junior colleague in training, participants may have felt duty-bound to participate in a research thesis, which they themselves will have completed in their own training. Although I cannot rule this out as having influenced participation, there were also psychologists within the department who did not respond to my invitation to participate in the study which indicated to me that a sense of obligation did not influence everyone's decision to participate.

Participants may have felt wary of discussing issues relating to clinical practice. This seems to have been a limiting factor as at three interviews, participants commented that they had wanted to provide useful responses. This is elaborated on more fully within the next chapters. Further, psychologists who did not participate may have regarded my proposed study as potentially scrutinising of them and therefore elected not to participate. Limitations aside, there were a number of incidences of personal disclosure which I interpreted as the participant feeling comfortable enough to share this information with me and having enough trust in me to keep this information confidential and interpret their data accurately.

Conversely, my role as both colleague and researcher had advantages; having an existing role within the department meant that I had a greater access to participants. I believe that participants' pre-existing experience of working with me may have helped them feel comfortable about participating in this research. Further, although my role of lead researcher in this study may have created a power imbalance, my role as junior colleague may also have addressed this somewhat.

I have made every effort to reflect upon these issues throughout the research process in order to address these limitations relating to my relationship to participants. Memo writing, research journaling and supervision sessions have been methods which have helped me to consider these aspects throughout the research.

Commitment & Rigour

Commitment is demonstrated by the researcher through a prolonged engagement with the subject and a substantive engagement with the relevant data (Yardley, 2000). I have demonstrated my own personal and professional commitment to expanding the understanding about CSA disclosure and implications within clinical practice.

Commitment may also be demonstrated by the development of methodological competencies and skills appropriate to this study. Throughout my training, I have conducted research projects which have involved developing such skills. Firstly, I have investigated aspects of clinical practice amongst psychologists through audit and secondly, I carried out research into a therapeutic approach for women with experiences of childhood trauma which relied on qualitative methods of data collection and analysis.

Rigour involves the thoroughness of data collection and analysis. This refers to the extent to which the sample can provide data which is sufficient to yield a comprehensive analysis. Rigour also refers to the "completeness" of the interpretations, which Yardley (2000) asserts should address the variation and

complexity observed within the data. To achieve a well rounded multilayered understanding of the topic, Yardley suggests using different methods of data collection and of validating analysis or 'triangulation'.

One aspect of triangulation was achieved through providing an 'audit trail' whereby sections of transcripts with coding and memos have been included within this chapter. Further, all notes, codes and diary records have been retained. This means that if required, all documents could be examined to provide evidence of the decision-making chain that occurred in arriving at the final report (Creswell, 2003).

Transparency & Coherence

Transparency refers to the clarity of description of what events occurred at what stage and the strength of argument that supported decision-making (Yardley, 2000). This is an opportunity to document reflexivity and account for my subjectivity within the research. This can be supported by the use of a reflective diary to document the research process. My reflective diary was used to consider my reflections of my own experiences regarding CSA inquiry and response and how they influenced my decision-making; my predictions of what participants would reveal to me; and my beliefs about what I felt was happening during interviews. I also used memos and journaling to reflect on my own emotional reactions during interviews and how this influenced further interviews and analysis.

The coherence of the fit between theory and method can also be evaluated. The findings of this study have been reported in following chapters and feedback was also sought from participants to ascertain whether they felt that the developing concepts were meaningful and coherent to them.

Impact & Importance

Yardley (2000) declares that a major test of the validity of research is whether it reveals anything useful or important or makes an impact in the field. The importance of this research is demonstrated in Chapter 1, as it has attempted to contribute to

what is known regarding CSA and clinical practice. Research into this area has become increasingly sophisticated from prevalence studies to clinician beliefs and behaviours and this study represents the continued efforts to expand research methodologies into this subject.

Further, the importance of this research has been demonstrated by the favourable responses received from professionals within psychology services and special interest groups for clinician working with survivors of CSA during discussion of the proposed research.

Due to the nature of GT methodologies, findings can be readily operationalized to be applied within research, practice and training. These findings have implications for future directions. Regarding the potential for impact, I plan to disseminate the findings of this study fully, as a journal article. Moreover, I will present these findings to the department from which participants were recruited and hope to do the same at national conferences.

3. Analysis and Discussion

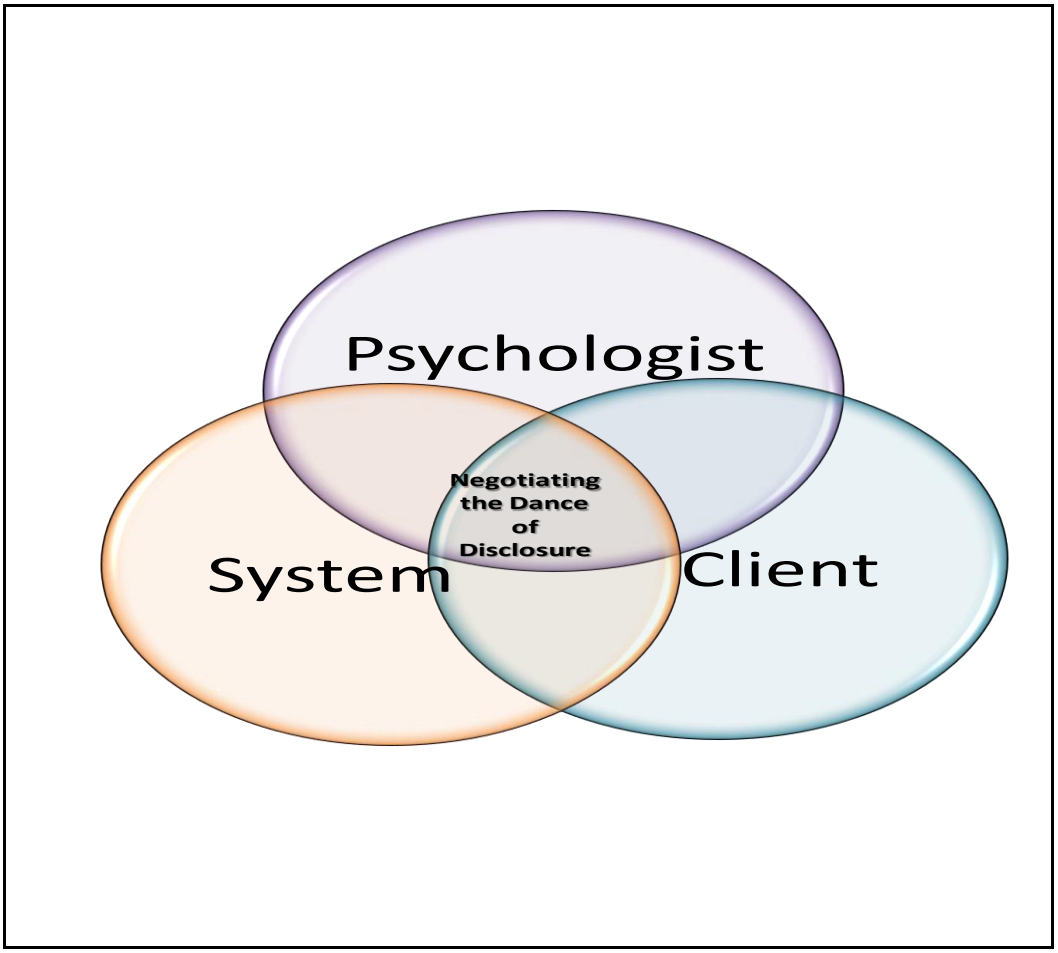
This chapter presents the analysis and discussion of participant interviews, which informs the construction of a theoretical model. The process of analysis involved constant comparison with the literature and resulted in four core categories, which are described in turn. Direct quotes are used to illustrate concepts and to evidence the development of codes and categories. Extracts from the interviews are used throughout to illustrate category formation. To reflect the constant comparative method of analysis, these categories will be discussed with reference to the literature in this chapter.

3.1: Results

The process of disclosure constructed within this study occurs in parallel with the psychotherapeutic relationship. The categories constructed account for the interactions between the psychologist, client and the systems which surround them. Four core categories entitled “Negotiating the Dance of Disclosure”, “Nurturing the Pre-conditions to Disclosure”, “Growing Personally and Professionally”, and “Carrying the Weight of the Work” are examined in turn and demonstrate the complex relationship between psychologist, client and the systems which operate around them.

3.1.1: Core Category- Negotiating the Dance of Disclosure

Figure 4. Negotiating the Dance of Disclosure



This category was formed gradually, throughout data analysis and collection (figure 4). It initially referred to the *emergence* of child sexual abuse disclosures, however this term did not seem to do it justice. Emergence raises connotations of a slow and steady process whereas for these participants, the process of disclosure rarely followed such a steady course.

Psychologists predominantly recalled experiencing disclosure from clients within the context of long-term psychological therapy. Some did describe incidents where they had been informed by case notes or in a referral note about a client's abuse history;

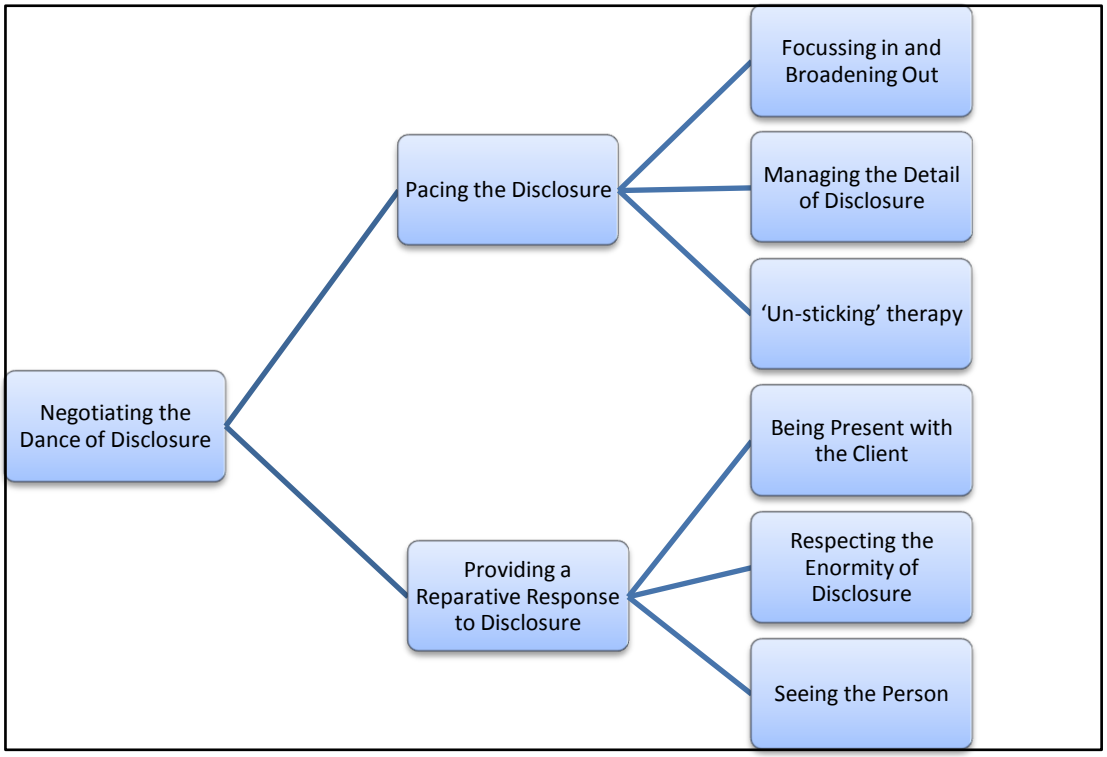
however this was discussed less often. Narratives of psychologists suggested a complex experience of CSA disclosure from clients.

Psychologists referred to their role in coaching this "dance", the pacing of which varies throughout the disclosure process. The nature of this dance seems to be shaped by factors linked to the psychologist, client, their relationship and the influences of the systems (i.e. professional, occupational, and governmental) in which the relationship exists. Within this dance the psychologists described a constantly changing and adapting approach with their clients where the pacing and content of the disclosure was regulated by the psychologist.

> *"...to me it feels a bit like a dance... like you're sort of moving forward sometimes with it and sometimes pulling back with it until they're able to tolerate discussing it".* (Participant 4)

The subcategories which contributed to the construction of this core category are named "Pacing the Disclosure" and "Providing a reparative response to Disclosure" and are featured in figure 5.

Figure 5. Subcategories of Negotiating the Dance of Disclosure



3.1.1.1: Subcategory- Pacing Disclosure

Psychologists recalled experiences of a disclosure process within therapy and the psychologists would encourage at a pace that they judged to be beneficial to the client. This can be seen in the following extract where disclosure of CSA followed earlier disclosures of physical abuse and neglect. This experience was characterised by the psychologist's slowing the disclosure process down when it became too rapid for the client to work with and then spurring them on when the progress stalled:

> *"we made fairly rapid progress and I actually felt I was trying to regulate it almost and slow it down, then we had paused for a while working on the memories of the physical abuse, the emotional abuse... the cognitive work on self-blame and guilt... that took quite a number of sessions... and then going back into [...] working on the memories, holding that for a while and then being able to talk about sexual abuse... so a sort of burst of progress, but not all the way through... and then a lengthy pause of holding it, and then a little bit more progress [...]you could think about the music and the rhythm of it when you're trying to hold it... not to go too fast or too slow".*
>
> (Participant 7)

Three important aspects of pacing were identified by participants: "focussing in/ broadening out", which refers to a means of pacing the content of disclosure while anchoring it to client's history, "managing the detail of the disclosure", which describes the psychologists' references to regulating the specific detail of the clients' sexually abusive experiences, and "un-sticking the therapy", which refers to a method of using disclosure material to drive therapy forward. For psychologists, pacing evolved throughout to hold the client in a 'place' where they could tolerate the disclosure process. The following subcategory, involves the psychologist's provision of a reparative response to disclosure and is discussed in the next section.

3.1.1.2: Subcategory- Providing a Reparative Response to Disclosure

Psychologists referred to the importance of offering a reparative and therapeutic response to hearing CSA disclosures from clients. This included demonstrating acceptance and willingness to validate the client's response, which many of their clients had been denied as children:

> *"if they're telling someone and they're believed and something is done about it and they're validated... I think a lot of the damage gets done around the secrets, lies, the fact that they had the sense that someone knew but didn't do anything about it [...]I think a lot of the damage gets done psychologically around those issues".*
>
> (Participant 4)

The ability to unconditionally accept the client and their disclosures was seen as highly important, whilst being able to validate the client's emotional distress. Failure to offer this would cause problems for the client and the therapeutic relationship:

> *"...you have to communicate acceptance, and non judgemental, and absolutely validate their pain and distress but also that it's not their fault, that they didn't deserve it... if you don't kind of do that immediately, that's going to cause a lot of problems".*
>
> (Participant 2)

Such validation demonstrates tensions between offering a genuine and helpful response to the disclosure, whilst being able to contain their responses of distress or shock. In the following example we see feelings of 'being taken aback' by the disclosure and how this was managed in therapy:

> *"...it's being able to give a genuine response. I think that... on a number of occasions when people have told me quite... kind of things that have caught me off guard, I've said "I'm really sorry that this has happened to you, it must have been a terrible experience" you're able to feed back, I suppose what my response has been to that [...] I think that it's very important to explain that you know... "I may have looked shocked by the way you told me" [...] I think that it's really important to let them know that it's not about them and you know it's not about any judgement that you've made about them and you can kind of clarify these things [...] I think to make people know that you feel that it wasn't an acceptable treatment of them".*
>
> (Participant 6)

However, there is also a sense that such feelings of the psychologist need managing, as their expression may otherwise have a negative impact on the disclosure of sexual abuse and the therapeutic relationship:

> *"I've come to understand that the worst thing that you can do is to show a reaction of shock or horror [...] So I think that you have to be prepared for it, educated about it... and almost expecting it. Then with experience, you can almost pre-empt it so that when it comes, you're not saying gasp! you know, and in that way, making people feel shameful you know. You're almost kind of saying "yeah, I kind of expected that... it's okay".*
>
> (Participant 2)

A genuine response from the psychologist must be moderated. If they express too much shock or sadness in reaction to the client's disclosure they may risk conveying to the client that what they tell the psychologist is intolerable, yet they must provide sufficient emotional response for the client to feel validated in their own pain. This represents another balancing act which the psychologist must achieve in the disclosure process.

Providing a reparative response to disclosure requires the psychologist to 'be present' with the client, respect the enormity of disclosure, and to be able to 'see the person'. 'Being present' and remaining engaged with the client throughout the disclosure can also be seen as a challenge:

> *"it's a very powerful moment for them, so you can't be at a point where you're too drained, or too exhausted, or too busy, or distracted... you know, you've definitely got to be in the room with them, giving your attention and care [...] because for them, that moment is huge, 'cause that's them saying, you know... for the first time... often".*
>
> (Participant 1)

Providing a reparative response also requires the psychologists' ability to respect the significance of the client's disclosure and how much this has to be kept in mind.

> *"I guess just realising for the person coming along... what a big thing it is... this person had been up all night worrying about speaking about it...just realising, I guess, the enormity of what it is that they're doing... what a big step it is... erm... I guess just really respecting that, you know, it's a big thing for them and it had taken a lot for them to get to that point".*
>
> (Participant 2)

Psychologists also described the need to prevent their knowledge of the client's abuse history from blinding them to the uniqueness and individuality of the client. Understanding the client and their resilience is a crucial aspect of the formulation process, just as conceptualising the impact of abuse. This psychologist describes her experience of feeling daunted by a client's case history prior to meeting them:

> "*... I'd been given her case, I read the case and I thought "oh, this is horrendous, I can't do this, why am I doing this job?!* [laughs] [...] *and then I met the person and they were pretty together, they didn't actually need <u>that</u> much work... and sometimes it's actually easier to see the person than read the file. Because then you see that it is a <u>person</u>, a real person that has demonstrated really quite an amazing degree of resilience".*
>
> (Participant 2)

"Negotiating the Dance of Disclosure" was constructed to describe psychologists' experiences of pacing their client's disclosure of sexual abuse whilst providing a reparative experience of responding to disclosure. Pacing of disclosure and the nature of the response needs to be attuned to what the client can tolerate, however this pace is an ever-evolving one which changes throughout the disclosure process. The concept of an ever modulating pace, which matched the client's level of tolerance seemed to mirror a theoretical concept in trauma therapy. This concept refers to a window of therapeutic opportunity that exists between the client's extremes of autonomic and affective 'dysregulation'. Although the experience of CSA does not necessarily lead to a traumatisation, psychologists' narratives demonstrated a trauma-informed model of clinical practice and are explored in a section of my reflective journal (appendix 7).

Briere (2002) introduced the concept of a "therapeutic window" within psychological therapy for trauma. He referred to a condition which is formed within the therapeutic relationship where the tools of the therapeutic model can be implemented. This window is a "*psychological location between overwhelming exposure and excessive avoidance"* (Briere, 2002, p.10).

The therapist is instrumental in holding the client in this window. If the therapist exceeds this window by incorrectly pacing or regulating the therapy, the client may become overwhelmed by emotion or memories relating to the traumatic event(s). An intervention which overshoots the therapeutic window may cause the client to dissociate from their emotional experiences, triggering maladaptive coping strategies (such as self-harm or substance misuse) and may rupture the therapeutic alliance. The therapist may 'undershoot' the therapy by employing insufficient evocation of trauma-related material. According to Briere, this may occur if a therapist avoids talking about the issues relating to the trauma and has little therapeutic value.

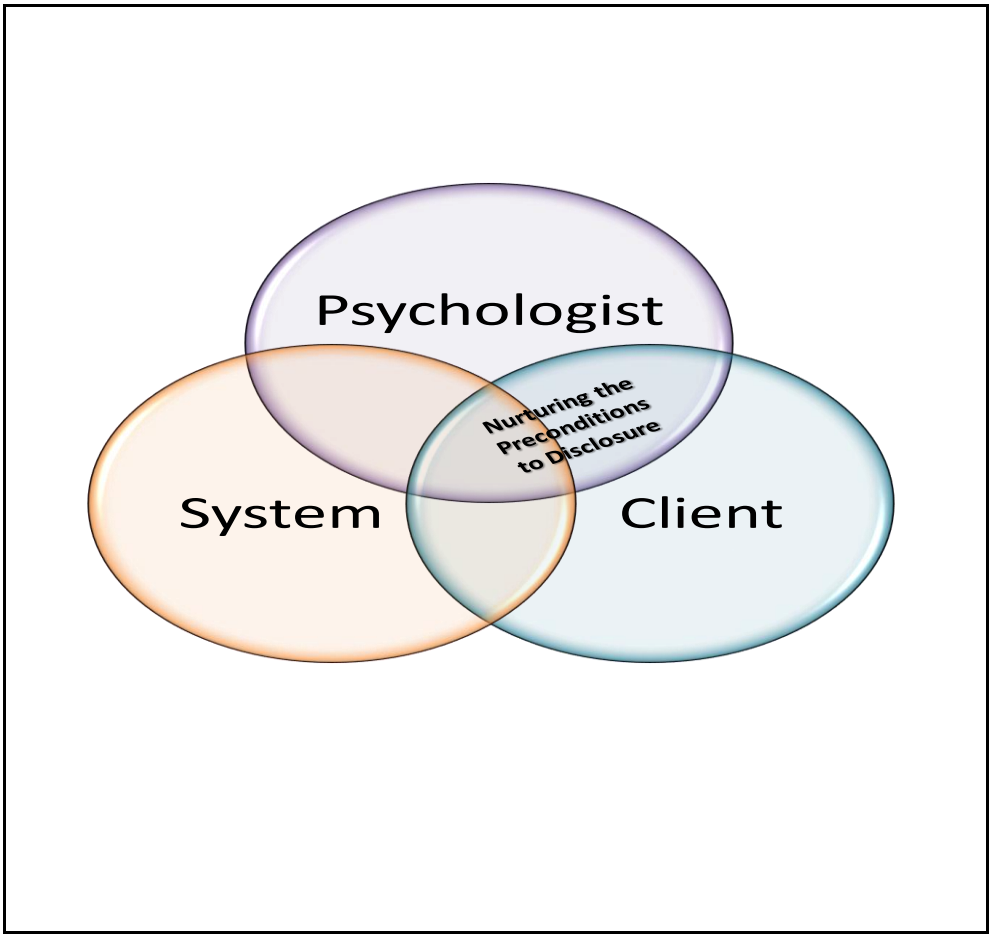
This window represents a "delicate balance", which cannot be static yet cannot be too intense or over-paced. Briere acknowledges that this window can be utilised in various therapy modalities, provided that the therapist is able to gauge the client's level of affect tolerance: *"interventions that take the therapeutic window into account are those that challenge and motivate psychological growth, desensitization, and cognitive processing, but do not overwhelm internal protective systems and thereby retraumatize [sic] and motivate unwanted avoidance responses"* (Briere, 2002, p. 10).

Psychologists' accounts of 'negotiating the dance of disclosure' seem to fit with this model of a therapeutic window where the psychologist must bring forth enough of the client's distress to sufficiently encourage active therapeutic work. However, care must be taken not to overshoot it so it is too traumatising, too damaging and too rupturing for the relationship to be of any benefit, whist remaining mindful of the opportunities to do this.

3.1.2: Core Category- Nurturing the Preconditions to Disclosure

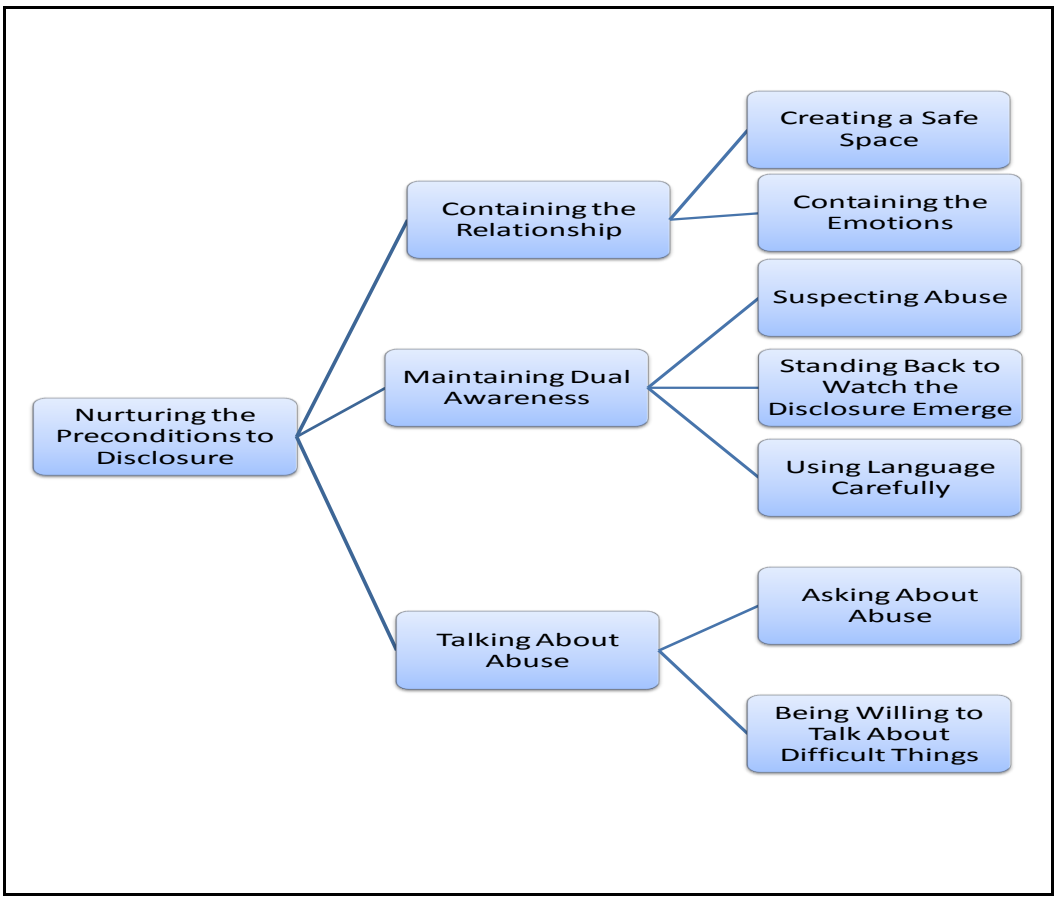
Analysis allowed for the construction of this category at an earlier stage than with the first core category (figure 6).

Figure 6. Nurturing the Preconditions to Disclosure



Psychologists referred to a number of complex conditions, which they felt necessary to ensure a safe and beneficial disclosure for the client. These conditions required the psychologist to contain the relationship, maintain dual awareness, and be able to talk about abuse (figure 7).

Figure 7. Subcategories of Nurturing the Preconditions to Disclosure



3.1.2.1: Subcategory- Containing the Relationship

Psychologists described containing and tolerating the client's emotions as a necessary precondition to disclosure. Containment is part of the therapeutic process which allows the client to reconnect with emotions and tolerate the distress.

> *"...all I'm doing is providing a way of... well, trying to contain the emotions, I suppose, for want of a better term, to sit with the emotions and let them experience them, and connect with the emotions, maybe that have been disconnected [...] so I'd be doing that, but I'm sitting there tolerating that and hopefully they would begin to tolerate".*
>
> (Participant 7)

The concept of creating a *safe space* was another property of establishing a containing relationship. This was illustrated in the discussion between Participant 1 and the researcher:

> ***ER[5]:*** *"**So you created some space for her, you created an environment that was perhaps calmer for her to be able to detail some of this stuff from earlier years?"***
>
> *P1:* *"Yes, to start giving some space, permission to talk about that".*

This was echoed by other participants:

> *"I suppose kind of allowing people to think, to consider, be aware that... I'm open to that and I want to hear about it [...] to create an environment where it* [CSA] *can be spoken about".*
>
> (Participant 6)

3.1.2.2: Subcategory- Maintaining Dual Awareness

This subcategory referred to the ability to engage and work with the client whilst monitoring the therapeutic process. Maintaining dual awareness corresponds with a divided attention model of information processing where the psychologist must strike a balance between attending to the client and to their own emotions and thoughts within the session. If the psychologist attends only to the clients' narrative's they may be less able to monitor their own reflections. Processes which occurred parallel to engaging with the client were: "standing back to watch the disclosure emerge", "suspecting abuse", and "using language carefully".

[5] ER= Researcher

Suspecting abuse to have taken place did not always result in immediate action but was kept in mind to inform further assessment and later inquiry.

> *"...there was a suspicion of something abusive had happened [...] not so much in the referral, but I got that suspicion from the first assessment and talking about, asking a little bit about past events, about memories of her childhood, what it had been like growing up".*
>
> (Participant 7)

This psychologist felt that her ability to have the suspicion of abuse and allow this to inform her gentle exploration of the client's history is a skill has developed for her with time and experience:

> *"...initially you're quite naive and you think that somebody can turn up and have such and such anxiety problem and you take it at face value and I think that I've learned over time, that actually there's usually something underlying that and quite often it's sexual abuse [...] so I suppose following up on clues like that, based on what they say [...] I would follow up a line when I think yeah, there is something missing from that story [...] over time, it's become less of a shock, 'cause you kind of think there's something else here, I'm going to wait until they feel that they can tell me".*
>
> (Participant 2)

This linked to another property of dual awareness which is labelled "standing back to watch the disclosure emerge". This describes the ability to witness the emergence of disclosure while actively engaging with the client. The psychologist does not know what sort of information may come out and they must feel able to tolerate the prospect of "opening" the client up for a disclosure to emerge.

> "*I tend to open things up very generally and just to hear how their story kind of pans out".*
>
> (Participant 6)

Psychologists reported this happening at differing paces however; many described this being a gradual process, with varied stages of pace. For instance, one psychologist described her experience with a client who had initially disclosed sexual

assault which she had endured as an adult, which then lead to CSA disclosure:

> *"it was all the rape initially [...] she was being triggered by so many other things that it was more kind of holding containing and stabilizing really, was what we were doing. Just holding her level and stable so she wasn't going in and out of the [inpatient] ward, and kicking off all the time. It would have been later that it [CSA] came out when I [...] felt that she was rather evasive in therapy... I was sort of thinking how do I tie her down a bit? Let's focus in a bit more, and it was when we, erm, we kind of went over, let's just you know, tell me your story a bit".*
>
> (Participant 1)

Maintaining dual awareness also involves the use of language. Psychologists explained that the client's use of language (and their own) is an important indicator of the client's ability to acknowledge and discuss their abuse:

> *"you need to be asking did anything difficult or traumatic happen... they might not have labelled it sexual abuse, so you have to ask it in a way that allows them to make a connection. They might not say to themselves that "I've been sexually abused"... they may dismiss it, you know: "oh it wasn't really abuse as it wasn't full on intercourse" [...] it depends how they categorised it in their minds so it might be that you have to ask that way".*
>
> (Participant 1)

This careful attention to language was echoed in another psychologist's experience with a particular client before they had been able to disclose sexual abuse:

> *"back then it wasn't calling it abuse, I was calling it "abusive behaviour from your father". So language was important until I could,*[use] *a very, very gentle process with her 'cause she would've disengaged otherwise [...] It was about paying attention to the language shifts, and the way that she would use language would give an indication of how she was progressing through the process".*
>
> (Participant 4)

The use of language is something which is negotiated and renegotiated throughout the disclosure process and can help the psychologist understand the client's unique relationship with their experiences.

3.1.1.3: Subcategory- Talking About Abuse

This refers to the psychologists' references to their experiences of talking about CSA with clients. This subcategory, asking about abuse refers to inquiry and what psychologists believed to be communicated to the client when they ask. The majority of psychologists within this study claimed not to ask clients directly about sexually abusive experiences as they felt that this would be too insensitive to the client or damaging to the therapeutic relationship. Once again, this appears to be another aspect of language which is negotiated between psychologist and client:

> *"'has anything bad ever happened to you?' and often you might get it through that...[...] if you pick up other forms of abuse or neglect or other kinds of abuse, erm... then I might sometimes follow that up, if it's appropriate, by saying 'were there any other kinds of abuse?', and I'd even follow that up by saying 'was there anything sexual?'... I might unfold it like that if I can go that far [...] I'm thinking of someone recently, where she wouldn't say the words... and I might say 'do you mind if I have a guess about what it is that we're talking about?... is this abuse?' so someone talking around it and I'm pretty sure that they're alluding to it but can't say it, then I say. So then they can respond to that [...] all of that's in the context with the rest of their history. I would never ask someone outright 'have you been abused?'".*
>
> (Participant 4)

Participant 4 described an incident where a client had been asked in direct terms about abuse by a different therapist in the past. This psychologist felt that this experience had been damaging to the client and caused them to leave therapy. In fact most psychologists spoke about a preferred way of asking about difficult events in the past without directly mentioning abuse but in a way that is judged to be manageable for the client. This is illustrated again in the following excerpt:

> *"It's one of those clinical judgement things isn't it? I don't think a very direct, putting them on the spot, it maybe in some cases, but generally I probably wouldn't use that approach [...] I mean if there had been some indication [...] if I felt that person was happy to discuss that. I might say something like "did that person ever touch you inappropriately, or do anything that made you feel uncomfortable?".*
>
> (Participant 3)

This illustrates how important the ability to 'tune-in' to the client and work collaboratively so not to trigger excessive distress, yet allow for exploration. There is also the need to respect the client's boundaries and negotiation and renegotiation encourages the client to provide feedback to the psychologist.

Psychologists also felt that (sensitively) asking a client about abuse was a way of communicating to the client that this is an important issue which may relate to their difficulties:

> *"I think permission and that there could be a connection to how they're feeling isn't it, that if you're asking about it then it's important in terms of what they're presenting with".*
>
> (Participant 1)

Participants felt that asking gave the client the message that the psychologist was concerned for them. They also believed that asking about abuse conveyed to the client that they had a degree of experience working with survivors of abuse, which would help to normalise the client's own difficulties whilst helping them to have confidence in the psychologist's ability.

The following psychologist described caution regarding how CSA inquiry is made to the client:

> *"I think it's important to keep on inquiring and I suppose that what you <u>don't</u> want to communicate by that is that you don't trust the person and not accept their first answer so you have to find different ways of asking it, but equally what you want to be able to do, the positive bit of that is to communicate that the door's open if you like, and even if they chose not to at the point of first meeting, or even at a later point, it's about saying that it's ok to add new information [...] I think potentially negatives are, you know if you do it artlessly, you end up maybe giving them a message that "I don't believe you, I'm not trusting you in some way because I keep asking you".*
>
> (Participant 7)

Once again, these results demonstrate that psychologists are aware of the high degree of sophistication which must be used in order to prepare the ground for a client's disclosure.

One participant, in particular, explained the importance of the psychologist being able to talk about difficult issues such as sexual abuse:

> *"If I'm going to be shy about discussing it, you know what message is that giving them?! [...] my backing off... in my eyes is not going to be particularly helpful, they're going to leave and think: "God! Bloody therapist is worse than I am!" [...] I guess talking about sexual issues is not necessarily something that everybody feels comfortable about but you know it's part of our job and if somebody is... assuming that the therapist themselves, you know, hasn't got some major difficulty in that specific area, I would think that it would... it's almost like you know a nurse who's blood phobic, maybe they have to kind of get over it (**uh huh**) erm, but to do so in a way which is going to be helpful for the patient you know [...] I think that as clinicians we have to do our best to... erm... be able to deal with these sorts of issues, or else we're in the wrong job!".*
>
> (Participant 5)

An ability to desensitise oneself to talking about uncomfortable, embarrassing or distressing topics is another pre-condition to disclosure. This appears to be something which psychologists' felt would become easier with time and experience yet remains unique to the individual clinician; however as Participant 5's quote indicates, there may be little room in the job for those that find this difficult.

This notion of desensitisation was echoed later by another participant who reflected on overcoming the taboo of discussing CSA as opposed to becoming desensitised to disclosure:

> *"Sometimes I worry that I get a bit too used to hearing those things [...] it sounds terrible but it's par for the course after a while, you know, you start to expect it [...] maybe it's not that we get numb to it, we just get past the taboo of discussing it and that it helpful for the people that come to see us [...] maybe it's not numbness, it just starts getting less scary".*
>
> (Participant 8)

The psychologist's ability to nurture the preconditions to disclosure from clients depends on three crucial aspects: the capacity to contain the therapeutic relationship with the client, the ability to maintain dual awareness and to tolerate talking about

sexual abuse. These are important abilities which may have roots in the most fundamental aspects of human behaviour and socio-emotional functioning

The Role of Attachment and Socio-emotional Development

The attachment system was proposed by Bowlby (1988) as a set of interpersonal behaviours which humans use from infancy to seek care and safety. The attachment system is proposed as an adaptive survival strategy for human infants, whose abilities to move, feed and defend themselves are under-developed. Therefore, their survival depends on their ability to seek proximity from others who are able to provide care and therefore reduce the infant's distress resulting from need (Mikulincer *et al*., 2003). The attachment relationship is the child's primary experience of the world and forms the child's first prototype for subsequent strategies of relating to others, self-reflection and emotional regulation.

The child's formation of mental representations is referred to as *mentalization* and has been defined as the *"capacity to make sense of each other and ourselves, implicitly and explicitly in terms of subjective states and mental processes"* (Fonagy & Bateman, 2008, p.5). It is theorised that the ability to mentalize originates from the attachment relationship where our ability to make mental representations of emotional states is developed through interactions with attachment figures from infancy. Initially, the child learns to imitate facial expressions and vocalizations of the primary care-giver. In an optimal (secure) attachment relationship, the care-giver and child undertake a reciprocal interplay of imitation and feedback which informs the development of a complex and dynamic capacity to understand oneself and others, their motivations, needs and intentions (Soderstrom & Skarderud, 2009). The capacity to reflect on one's own thoughts and emotions is crucial to conceptualise and regulate one's behaviour, emotional and physical arousal. Both the capacity to mentalize and regulate emotion is cultivated within the attachment relationship (Fonagy *et al*., 2002).

This model assumes that issues such as training, supervision, support and clinical experience goes some way to help the psychologist feel able to experience the disclosures of clients in Adult Mental Health. However, this does not solely explain,

for instance why some psychologists may experience nurturing the preconditions to disclosure with more difficulty than others.

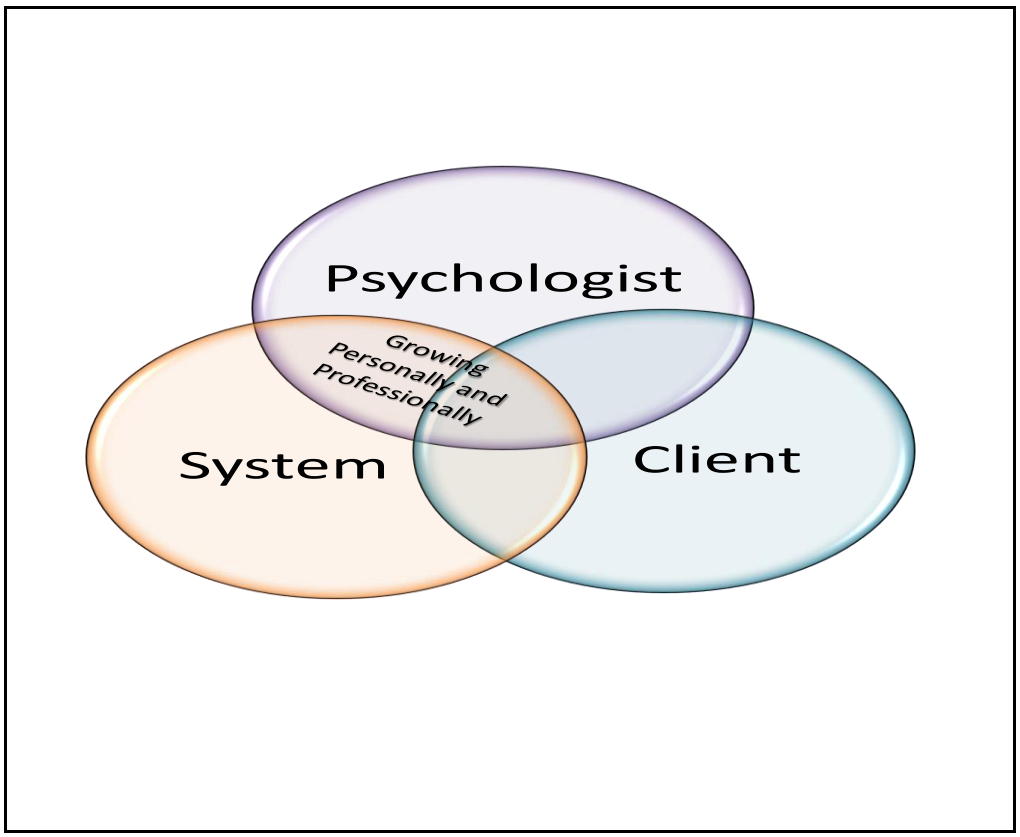
Maintaining dual awareness may represent the psychologist's ability to mentalize and reflect on their own emotional states and thoughts while attending to those of the client. The capacity to contain the therapeutic relationship is likely to be informed by the psychologist's own attachment style. Moreover, the ability to talk about sexual abuse in childhood may represent a process of desensitisation (as participants 5 and 8 suggest) but also will be a function of emotional regulation.

3.1.3: Core Category- Growing Personally and Professionally

This category emerged as psychologists discussed a sense of growth occurring in the context of working with abuse survivors and disclosures of abuse and the supports within the system (figure 8). The notion that there are positive aspects of working with disclosure seems to lacking in the literature. However, a review of the vicarious traumatisation literature by Chouliara and colleagues (20009) identified five studies, which reported unanticipated benefits for clinicians working with traumatised clients.

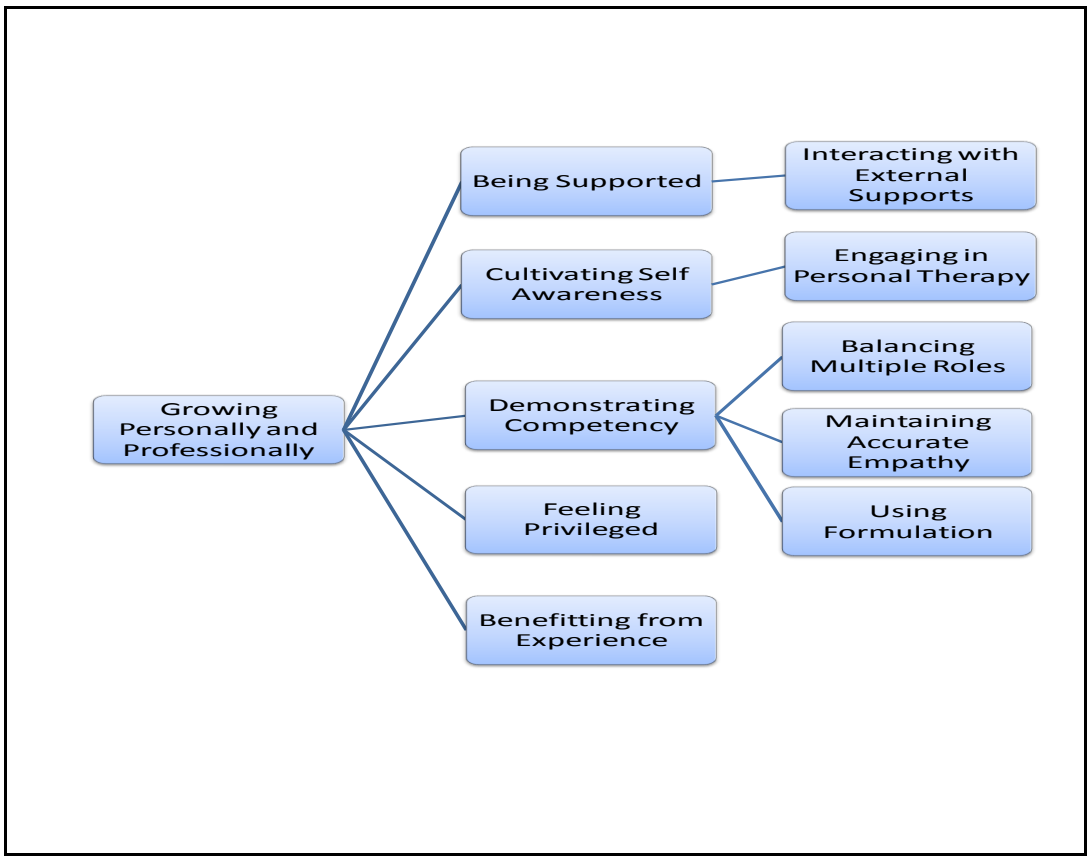
These studies highlighted a strengthened sense of identity, purpose and a greater sense of spiritual well-being. This current study also demonstrated the positive aspects of the work experienced by psychologists such as a sense of privilege, value in the work that they do and the role in which their experience of the work has in helping them to become more skilled in their work with survivors.

Figure 8. Growing Personally and Professionally



The subcategories of growing personally and professionally are presented below in figure 9. Psychologists described the importance of being supported in their direct work with the client, and also helping them to develop skills in supervision and management of other psychologists. Experiencing disclosures from clients required psychologists to cultivate greater self-awareness and allow them to demonstrate competencies. The cumulative benefit of working with survivors, hearing disclosures and helping clients make disclosures was reflected on by psychologists. Furthermore, psychologists understood how significant disclosures were for clients, and the therapeutic relationship, and they described feeling a sense of great privilege when they felt entrusted with a client's disclosure.

Figure 9. Subcategories of Growing Personally and Professionally



3.1.3.1: Subcategory- Being Supported

Psychologists in the study described their experiences of being supported in working with CSA disclosures. Supervision was perceived as an important means of talking about disclosures:

> *"Supervision is key [...] if there is something... either strong emotions that you feel that you've been left with or even it'd be good just to kind of de-brief, erm in a supervision setting or kind of peer supervision, I guess where there's someone you could call if they were around".*
>
> (Participant 3)

Another psychologist described how promoting an open ethos in supervision helps her colleagues to manage the effects of hearing disclosure. She felt that this represented an important paradigm-shift in the Clinical Psychology profession,

which historically has been less inclined to openly promote self-care and self-reflection.

> *"it takes a level of confidence, I suppose, so that you're happy to expose yourself a little bit like that, I think it's really important 'cause there's a history in psychology of that not always being there... that we're somehow supposed to be sponges to listen to that sort of stuff... think about the percentage of your working week and how much you're being exposed to distress and disturbing stories then, I think it's madness to not think that it's going to affect you and not to take care of yourself and it's madness of managers to not be paying attention to that in their staff but I think that there's a history of this idea: "well that's the job that you do and you just get on with it", I think that there's a bit of that ethos there that's hopefully breaking down".*
>
> (Participant 4)

Psychologists referred to their use of child protection and peer support systems following CSA disclosure. This psychologist found the ability to liaise with colleagues in child psychology services helpful when unsure about whom to contact with child protection concerns:

> *"I usually go and speak to someone from child* [psychology services] *and get information about what are my responsibilities, what can I do about this, given the information I have, and they've been really good [...] you know what steps to take".*
>
> (Participant 2)

Within this health board, dedicated child protection professionals were available for consultation and advice regarding concerns about a client's disclosures. Psychologist's knowledge that they could pick up the phone and ask questions was seen as important. The existence of clear child protection procedures within the service was also valued in supporting their work:

> *"especially with the child protection stuff, knowing [...] that it's not vague, that it is some sort of definite procedure that you follow and, that there are those contacts there that can respond".*
>
> (Participant 3)

This appeared to contrast with the views expressed by therapists in the study from Chouliara *et al. (under review)* where participants described managing child protection issues difficult due to concerns about breaking client trust and rupturing the therapeutic relationship. Rather, in the current study, psychologists felt supported by the child protection system, which gave them confidence in adhering to child protection policy.

3.1.3.2: Subcategory- Cultivating Self Awareness

This subcategory refers to the development of self awareness which psychologists recognised as essential in managing the emotional impact associated with working with disclosures. This was illustrated in discussion with participant 1:

> ***ER: "So self-awareness, emotional awareness, is a grounding experience, protective experience?"***
>
> *P1: "It is a protective experience, it somehow means not being dislodged or wavered [...] staying steadfast in an emotional way [...] everybody's going to get buffeted sometimes, you're not going to be immune to that [laughs] obviously, but you get more aware of it".*

Within psychodynamic and counselling literature, personal therapy is a means of understanding the role of the therapist's own material in clinical practice. Therapists must be able to reflect on the countertransference occurring within their relationships with clients. Barriers to reflection may cause the therapist and client to act out 'the same old' patterns of behaviour, which may impede therapy or even become dangerous for client or therapist (McCann *et al.*, 1999).

The experience of personal therapy was seen by these psychologists as a means of understanding the client's position in therapy. Additionally, personal therapy was viewed as a vehicle for cultivating self-awareness of their role in the therapeutic relationship and issues of counter-transference. However, it was felt that this was less emphasised within the clinical psychology profession:

> *"if you've been there yourself then you can much more, I don't know, work with that person, another human being, in distress, in the moment, because you know what that feels like. I think that just because you've been through your own stuff, doesn't mean that there's necessarily going to be any problems, I think it can be used and it can give you more empathy... erm but only if you've worked through it, otherwise it's really dangerous [...] I think that it might help you avoid less, I think it might also help you understand what's going on in that therapeutic relationship and your own part in that".*
>
> (Participant 2)

However, there were allusions to tensions within the clinical psychology profession with regard to personal therapy:

> *"that again... comes back to clinical psychology not asking people to go through their own therapy [...] Even if you just had 10 sessions, just, especially at the beginning, 'cause you start to do that as you go through your career... you get to know yourself...a lot and which clients you find easier and which clients really trigger you and get you going. But wouldn't it be really helpful to have some basis to that initially, some sort of therapeutic experience itself? (**Sure**) to identify your own stuff, because that's what you have to be able to do in this work".*
>
> (Participant 1)

The notion that personal therapy should be encouraged more by practising psychologists was further echoed by others, particularly the role of personal therapy whilst training. This resonated with my own beliefs that personal therapy should be better encouraged within clinical psychology training.

3.1.2.3: Subcategory- Demonstrating Competency

This subcategory refers to aspects of competency, which the psychologists in this study felt were necessary in helping them work with CSA disclosures.

The ability to balance multiple roles for psychologists was discussed with reference to working with clients who disclose. Roles undertaken were described as: assessing suitability for psychological therapy, containing and normalising the clients' emotions, helping the disclosure to emerge, showing knowledge and understanding

of CSA issues, keeping in mind child protection issues, and assessing risk to the client.

This psychologist describes how the demonstration of knowledge and skill is important for the client in being able to disclose abuse which '*perhaps demonstrates a degree of proficiency, familiarity, you know, the patient is almost relieved to think "well here's somebody who knows that this is likely to be a problem'.*

(Participant 5)

The ability to maintain empathy was described as an important competency for psychologists to develop. One psychologist elaborated on the concept of "accurate empathy" for the client, which involves the ability to feel a genuine empathic connection with the client. At the same time, attempts are made to refrain from being pulled into the client's distress or trauma so that the boundaries of therapy become blurred, rendering the psychologist unable to help the client:

> *"Inaccurate empathy might be almost, you could see as an overly sympathetic response. You could argue that's our stuff, getting in the way there saying "Oh my god, that's awful, that must have been horrific!" and it might have been, it may well have been and maybe for most people that's exactly how it was so it's not doing any harm... but for some people, they would frame it differently, even subtly differently, and that's accurate empathy about trying to find their language, trying to find their experience for it and empathise with that".* (Participant 7)

Keeping a balanced sense of empathy may change as the psychologist becomes more experienced and practiced in hearing distressing and traumatic material. However, one psychologist warned of the risks of losing the capacity to establish an accurately empathic connection with the client by becoming overly desensitised to CSA:

> *"the more you do anything the easier it becomes but as long as it doesn't become insensitive, as long as you don't lose the capacity to be sensitive to what the patient's needs are [...] you've got to constantly try to not allow repeated experience to make you less empathic".*
>
> (Participant 5)

A loss of empathy is regarded within the literature as a risk associated with secondary trauma. Burnout, which is associated with psychological strategies such as depersonalisation, may occur from excessive stress of the work. The emotional numbing symptom of Compassion Fatigue and a sense of disconnection from others associated with Vicarious Traumatisation may also manifest in a loss of empathy in the clinician.

The ability to balance empathy with a "*healthy detachment*" was seen as a developing competency by one psychologist:

> *"you can't be empathic if you're completely with the person. It's this funny concept, where you know, you think you're in another person's shoes, but if you're completely in another's shoes then you're not empathic, you're actually living their life, you have to have that detachment and yet engagement [...] what you're doing is holding one foot in the present and with you yourself, your knowledge of yourself and your knowledge of what you're doing, and one foot in with the person, and understanding where they are... so instead of putting yourself in their shoes, you're putting yourself in <u>one</u> shoe".*
>
> (Participant 7)

Accurate empathy necessitates an awareness of personal boundaries and seems to be strengthened by experiences of supervision and personal therapy, but may also be affected by the emotional burden of the work.

Psychologists discussed the use of other therapeutic skills such as formulation as being useful in not only developing an understanding of the client, but also establishing a collaborative working relationship with the client. Formulation is a fundamental competency within the clinical psychology profession, which was seen as not only a necessary aspect of the work, but an important skill to demonstrate to the client:

> *"you also need to be keeping in mind things like psychological theories, like the fact that [behavioural] exposure helps people get over these things and it's combining human element, human side of you, that empathic element".*
>
> (Participant 4)

The ability to use formulation in understanding the client's difficulties contributed to their sense of credibility in being able to do the work. The demonstration of competency by the psychologist seemed to have an importance on their ability to work for a client and allows them to have confidence in the psychologist's ability to help them.

3.1.2.4: Subcategory- Feeling Privileged

Another aspect of personal and professional growth relates to the personal value that they placed in a client's disclosure. Psychologists' described a sense of privilege from a client's choice to disclose to them. This was the understanding that disclosures are important, yet place the client in a vulnerable position which must be treated with care and respect. For example:

> *"you feel privileged as well, in a way, you know, that they're feeling able to tell you these things that are obviously very personal and can be really upsetting for them and they're trusting you with that".*
>
> (Participant 3)

The psychologist must also be able to demonstrate to the client that they can be entrusted with this honour.

3.1.2.5: Subcategory- Benefitting from Experience

This subcategory referred to the experiences (practical and formal teaching), which the psychologists felt benefitted their ability to work with CSA disclosures. Psychologists, who had been qualified for a longer period, received less formal teaching about childhood sexual abuse and trauma in their clinical psychology training. Psychologists who received pre-qualification training in CSA issues completed this within placement training, delivered by professionals within their health board with specific special interests in working with sexual abuse survivors rather than any specific service plan:

> *"It just depends on the interests [laughs] and funding and whatever else... of people who happen to be working around the area of your training course. There was a specialist sexual abuse service, within the health board and so staff from that service came and trained us, and that was very good and one of my placements was in a department attached to that clinic, not directly with the clinic but we shared a building and CPD [continuing professional development], and all sorts of different things so I suspect that my experience was better than average [...] some very excellent clinicians who are very passionate about this area, working there".*
>
> (Participant 3)

No psychologist described undertaking any formal training regarding CSA disclosure and inquiry. Rather, the experiences which psychologists felt most benefitted them in their post-qualification work were self-directed or obtained through connections with special interest groups. Yet again, personal therapy was described as another potential learning tool:

> *"I would say that my own experiences of therapy were my best teaching in therapy (**uh huh**)... I would say learning from other people with more experience through supervision and work that I had done on myself, and reading... less so on about abuse but more so on reading about approaches like Schema Therapy".*
>
> (Participant 4)

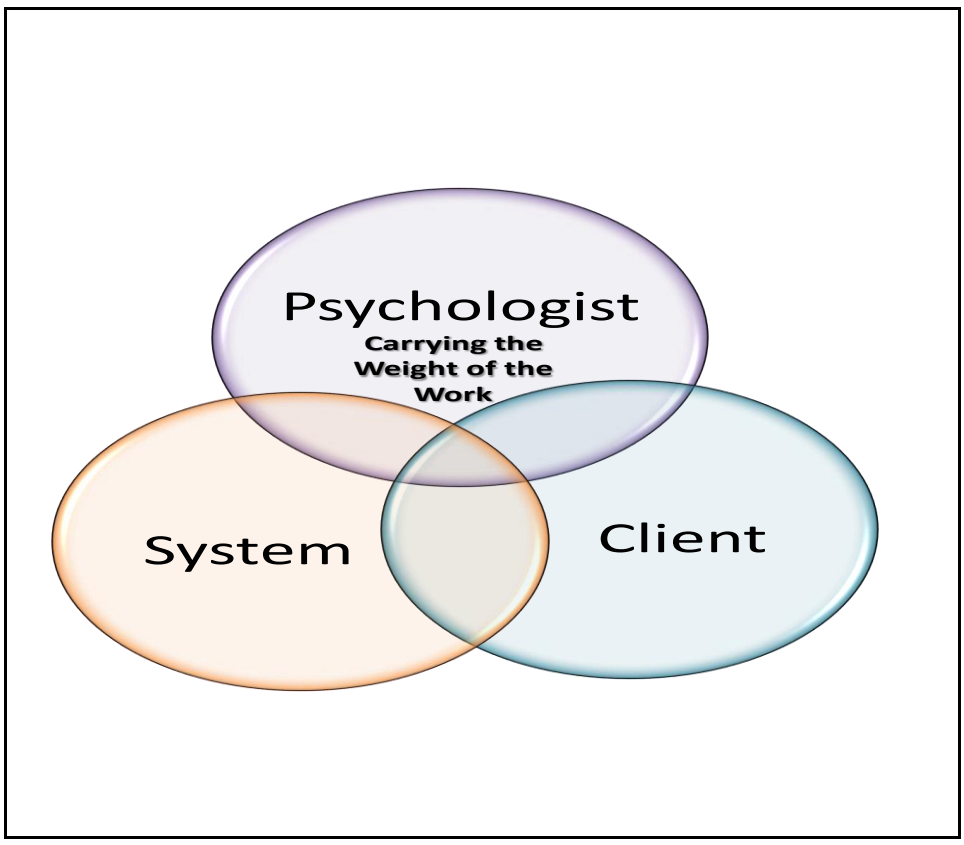
Despite CSA having been recognised within the therapeutic literature since the 1970s, psychologists who trained around that time recalled little in the way of training which was relevant to working with survivors:

> *"it was recognised but I don't remember getting any formal training, that's come through reading, through clinical contacts which have prompted further reading".*
>
> (Participant 5)

3.1.4: Core Category- Carrying the Weight of the Work

This category emerged to account for the complex and difficult aspects of hearing disclosures of abuse and also preparing the ground for disclosures to occur. This category is mediated by the interaction of the other core categories and is modelled in figure 10. The weight of the work may potentially prevent the psychologist from spotting opportunities to ask about abuse or being able to hold the client in the therapeutic window long enough to allow the dance of disclosure to occur. Psychologists conveyed a real sense of trying to be mindful of this dance, nurturing the preconditions to disclosure and growing with the work, whilst being able to keep the burden of the work from impacting on them.

Figure 10. Carrying the Weight of the Work



Some participants described their experiences of hearing disclosures as "depressing" "distressing", and difficult to stop themselves from thinking about it:

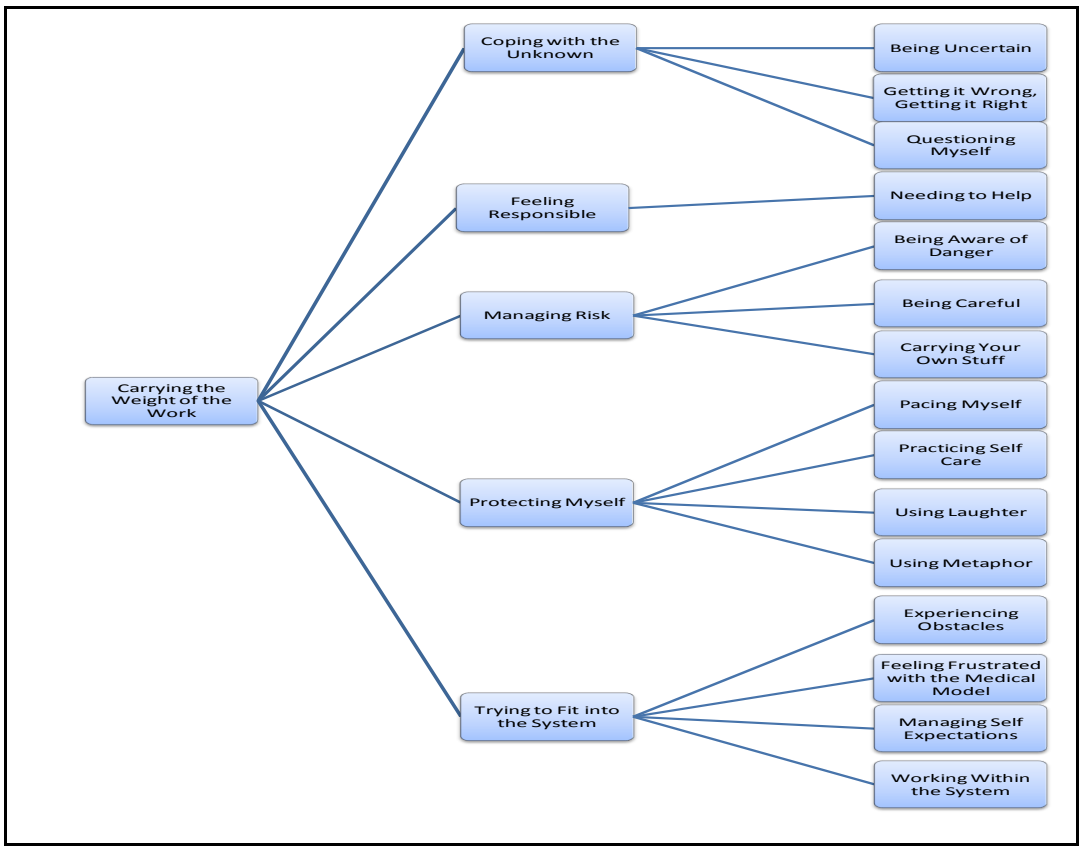
> *"it's just awful the things that you know, man's inhumanity to man, the sort of things that people can do to their children, it's dreadful, and you're there hearing that".*
>
> (Participant 1)

> *"you can see it and you just feel... unable to do anything about it. I suppose it's seeing the worst about humanity".*
>
> (Participant 2)

Another spoke of her feelings of anger towards the parents of clients when responses, to reporting the abuse in childhood, had been minimised, describing their reactions as *"completely inadequate and really damaging"* (Participant 8).

The subcategories within "Carrying the Weight of the Work" are presented in figure 11.

Figure 11. Subcategories of Carrying the Weight of the Work



3.1.4.1: Subcategory- Coping with the Unknown

Respondents talked about the feelings associated with uncertainty in working with survivors and CSA disclosure. This was commonly experienced as anxiety and concern:

> *"you think: "did I push her too quickly?" and, you know (**uh huh**)... "should I have taken things slower?"... I suppose you kind of blame yourself a bit".* (Participant 2)

This uncertainty appeared to resonate with other psychologists:

> *"I guess there's always that part of you saying "oh could I have said that better? Or done that better?".*
>
> (Participant 3)

> *"I have had some people who... I've, along the way have misgauged their readiness to hear things...[...] You just kind of assume that people <u>want</u> to make sense of things and they want information and they want to kind of pull things together but in the experiences of presenting formulations to people and they have just been overwhelmed".*
>
> (Participant 6)

An opportunity to learn from experience seemed to come from acknowledging this uncertainty, indicating that perhaps the effect of coping with uncertainty varies. Self-awareness and the capacity to reflect on these feelings were essential useful in the psychologist's development and desire to improve their practice.

One psychologist refers to engaging in self-questioning with regard to whether discussing abuse with a client was the right thing to have done:

> *"maybe, just maybe in this particular case [...] one wonders whether in fact it was the right thing... of course, I don't know, maybe she would have been even worse, but it became such an all consuming issue and so entrenched and various people had been, in the past prior to my seeing her, had been involved in exploring the issue that she had become almost, for want of a better expression [...] it had become her raison d'être".*
>
> (Participant 5)

Even my questions about CSA disclosure and inquiry elicited uncertainty for this participant:

> *"I guess anybody in my position, who is involved in this, there is inevitably perhaps, an element of what's the right answer here?"*
>
> (Participant 5)

The use of a reflexive journal and memos (see section 3.2) helped me to explore this issue. The desire to "get it right" and the aversion to "getting it wrong" became an important aspect of coping with uncertainty:

> ***ER: "It sounds like it's a really valuable thing to be able to reflect on your experiences** (yeah). **What do you think has helped you to do that, to acknowledge your mistakes?"***
>
> *P6: "To be able to reflect back? **(yeah)**, erm... the desire to get it right!"*

One psychologist described her experience of 'missing' the hints that her client had made to her about being abused, which had been known by other staff. She had learned from this experience not to assume that one always has a complete history of a client even when their involvement in the mental health system dated back many years:

> *"it's like received wisdom I suppose... this person has this kind of history and these kind of problems and this is what you need to work on and [...] I felt that I should have asked her some more direct questions, erm... and she was sitting there assuming that I knew these things and that maybe I was choosing not to talk about them or that I didn't think that they were relevant".*
>
> (Participant 8)

This further demonstrated that the psychologist's understanding and knowledge of the client is constantly evolving.

Again, this uncertainty seems to either help or hinder psychologists. If they 'own' their uncertainty and use it to reflect on their experiences then this seems to encourage learning and development. However, if the psychologist, for whatever reason is unable to acknowledge and work with their uncertainty, then they may risk engaging in strategies to avoid their feelings which may be harmful to both the client and the psychologist:

> *"I guess you realise how important it is to get it right, particularly in these cases... as right as you can, you don't want to lose people and for their experience of disclosure to have been a negative one because it's going to be important for them at <u>some</u> point down the line, probably for them to do that again".*
>
> (Participant 6)

> *"I think the general issue there is that there seems to be most psychologists... possibly most health professionals are very sensitive to the thought that they might be getting something wrong might, miss something out and that assessment, erm... probably triggers all sorts of anxieties".*
>
> (Participant 7)

3.1.4.2: Subcategory- Feeling Responsible

Psychologists demonstrated an awareness of how important their role in negotiating disclosures with their clients was and their responses to this information. This formed another sub-category, which related to the weight of the responsibility in working with survivors. Psychologists referred to a sense of duty to put things right for clients who disclosed CSA. This seemed to be intensified when psychologists had caseloads of more than one abuse survivor:

> *"if you have a caseload with quite a few people like that then it can feel quite overwhelming at times (**uh huh**) and I guess that the sense of responsibility in that role, you know, goodness these people have been through so much that I really want to help"*
>
> (Participant 6)

3.1.4.3: Subcategory- Managing Risk

This subcategory refers to psychologists' management of risk relating to the client, but also a sense of risk that they perceived in working with abuse disclosures. This involves the potential risk of mismanaging the disclosure and the risk that may be posed to the client in 'opening them up' to disclose. Accessing memories and emotions that the client may have successfully avoided, can trigger risky coping strategies such as self-harm. The danger of 'missing' important information, such as the risk that the client's abuser may still pose to children, was also something which concerned psychologists. Further, they described the risk to the psychologist in terms of the emotional burden of the work.

One psychologist described her frustration in a scenario where a client had disclosed their abuse and that their abuser was still alive. However, the client was reluctant to reveal the name to child protection services:

> *"It's really frustrating if the client won't give you any information and you think that this person could still be out there, and what is actually going on now [...] So you've got to be quite vigilant".*
>
> (Participant 2)

Another psychologist recalled the damage that she felt had been done by another therapist whose "*flippant*" remarks about how common CSA is to the client had left the client feeling that her distress was an overreaction. She describes the importance of caution in responding to disclosures:

> *"I think it's those sort of flippant remarks... you have to be really careful about not making them... it's better to say nothing, just give them acceptance rather than to say something that's potentially damaging like that, that's potentially also irreversible".*
>
> (Participant 4)

Psychologists also made reference to needing to be careful about the impact that this work may have on them. In this instance, a psychologist made explicit reference to vicarious traumatisation:

> *"You've got to be careful how this sort of work affects you because we know that it can affect how people see the world, that sort of vicarious trauma [...]the idea that as a therapist you could end up starting to see things differently [...]I think sometimes, it's also easy to miss the emotional, or find it hard to talk about the emotional effects of the cases, you know a lot of us avoid that to a degree and we may not always wish to discuss it but there's also the sort of cognitive effects with how we start seeing things and I think that can build up and build up"*
>
> (Participant 7)

There appeared to be a real awareness of secondary trauma amongst participants. The issue of "carrying your own stuff" also formed part of this subcategory. This referred to psychologists' own childhood experiences and tendencies to self-sacrifice. They described the importance of striving to develop an awareness of their "own stuff" to enhance their work. The extent to which the psychologist's own experiences could affect their work was seen as important in relation to personal trauma history. One psychologist disclosed a personal history of physical and emotional abuse in childhood, which she felt added another dimension to working with all survivors of childhood abuse.

Another psychologist described personal therapy as being helpful in developing this self awareness:

> *"as you work... you obviously become aware of your own stuff, is so you can do that for yourself a lot but everybody needs somebody external to that [...] To identify your own stuff, because that's what you have to be able to do in this work".*
>
> (Participant 1)

Pursuing this topic in interviews lead onto many psychologists discussing the difficulties that they believed may arise when psychologists are survivors of CSA themselves. In some instances, psychologists did not feel that this would necessarily hinder a psychologist's ability to work with survivors provided that they had "worked through" their own abuse issues and that self-reflection and being able to discuss this openly in supervision was seen as vital regardless of life experiences:

> *"Yeah, obviously that is going to be a lot more difficult for them to deal with... those people, I would assume that those people would choose to enter therapy themselves... knowing that they were going to have to deal with those things themselves [...] but I guess you're always aware when you're looking through files and things, there's always going to be something that's more triggering for you... and as long as people are aware and as long as mechanisms are in place to protect us to some extent, if there are cases for whatever reason that we can't manage to the best of our ability, then I think we have a duty to ourselves and to those people to discuss that with a supervisor to make a decision yourself about whether or not that's something that you can deal with at that time".*
>
> (Participant 6)

One psychologist felt that therapist-survivors may be less tuned into the client and more avoidant of asking about abuse:

> *"I think it [CSA] crops up all the time, and I'd imagine that if somebody had been sexually abused then they would steer away from that subject and give completely the wrong message about it".* [6]
>
> (Participant 2)

[6] A journal was used to consider my feelings about this interview and allowed me to explore some of the unspoken attitudes held by psychologists (as described in the next section).

3.1.4.4: Subcategory- Protecting Myself

The subcategory "protecting myself" emerged as a counterbalance to the sense of risk ,which psychologists described to be present in working with CSA disclosures. '*Pacing myself'* and '*practicing self' care* referred to strategies which psychologists employed to support them in their work:

> *"Time to reflect... time to ...almost debrief yourself...a bit before you have the next person come in. To just take stock of what happened, write your notes. The worst thing is when you've just done that, and then you go straight into it with someone else, no time to write up your notes... you go whomp from the one to the other...and you haven't really emotionally landed... from one before you move onto the next".*
>
> (Participant 1)

Allowing personal time and space seems to be an important protective factor for psychologists, however this may not be realistic when the nature of the work requires many to hold large caseloads of clients. Psychologists described various methods of self-care and maintaining a work-life balance:

> *"a life outside of that... you need a life [laughs]... you need to have fun and you need to have all of those things which you know that you should do... like exercise, which I don't do, but I know that it's good for me... things to de-stress yourself, whatever that is [...] You need to keep an eye of that, and I think that the very nature of the people that we are, we're come into a caring profession, you can be a bit of a subjugator... or self sacrificer... you may have that element within you... you've got to be careful of that. I know I have that element within me and I have to be careful".*
>
> (Participant 1)

> *"I think it's important to look after yourself [...] I get regular acupuncture, I get shiatsu [...] I've had therapy, I... erm, I'll get massage done".*
>
> (Participant 4)

Participants recognised the need to look after themselves holistically through exercise, personal therapy, meditation and alternative therapy.

Two further self-protective strategies entered this subcategory. These referred to

strategies which psychologists used when discussing their experiences with CSA disclosures, within the context of these interviews. These are referred to as *using metaphor* and *using laughter*. The use of metaphor by psychologists and the researcher became more conspicuous through ongoing analysis. Some metaphors referred to the interaction between psychologist and client. In addition to psychologists' descriptions of the disclosure process as a "*dance*", a "*journey*" (Participant 4) or riding a "*teeter-totter*" (seesaw) (Participant 7), another psychologist referred to CSA inquiry as a necessary step when she felt that therapy had stalled. She described this as "*roadblocks*" in therapy (Participant 5). My use of metaphor described a sense of the client giving the psychologist clues about abuse in order for the psychologist to inquire further (*"laying down breadcrumbs"*) and the psychologist contributing to the preconditions of disclosure (*"sow the seeds"*).

One psychologist likened hearing one client's disclosure to the completion of a puzzle:

> *"when we did uncover it, it helped to make sense of a lot of thing [...] it was hard to piece together some of the very specific things that she found difficult and this was just like the final piece to the jigsaw".*
>
> (Participant 6)

The metaphors used by psychologists within the study also symbolised a sense of hazard or uncontrollability, relating to the consequences of discussing CSA with clients:

> *"I guess that's peoples' worry often then, that the floodgates will open and you don't want that to happen for them in a way that feels uncontrollable".*
>
> (Participant 3)

Another described pacing inquiry and emerging disclosure as precarious, particularly within a first appointment with the client:

> *"sometimes being able to do the first assessment and not being too thrown by it and not making into something that it's not, it's not under-playing it, it's not over-playing. It's like walking a tight-rope, not going too far either way".*
>
> (Participant 7)

One psychologist described the potential risks associated with an insensitive approach to CSA inquiry, particularly in instances where clients do not present with typical indicators of CSA:

> *"if somebody presents with a fairly circumscribed difficulty then no, I wouldn't necessarily start <u>looking</u> for it and seek to discount [CSA history] in some almost blunderbuss fashion".*
>
> (Participant 5)

Further, this psychologist described her reluctance to encourage CSA disclosures:

> *"it can open up a hornet's nest, where there are some things that are probably best not to have... been explored in depth".*
>
> (Participant 5)

Metaphors were also used to describe working around the danger of directly talking about a client's abuse:

> *so you can still work around abuse without going straight into the trauma... the eye of the storm...*
>
> (Participant 4)

The use of metaphor by therapists has been theorised to serve a number of functions. Metaphor may allow for the therapist's communication about highly personal aspects of the client, whilst removing some of the detail, permitting a greater

'generalisability' of experience (Berlin *et al.,* 1991). Relational Frame Theory (RFT) is a concept from Skinner, which is used in Acceptance and Commitment Therapy (Barnes-Homes *et al.* 2004). According to this view, metaphor serves to transform the function of one's emotional experience to allow the individual to create meaning and communicate this to another. Comparing participants' narratives with this theoretical literature demonstrated to me that metaphors may serve a protective function for psychologists. This conveys the emotional experience of CSA disclosure from clients. At times, making the psychologist feel hopeful and at other times fearful or anxious regarding the consequences of their client's disclosure may be overwhelming or risky to both the client and the psychologist.

Similarly, the use of laughter by psychologists was also apparent at interviews and in analysis. Laughter conveyed a number of things to me. Firstly, psychologists laughed at points which seemed incongruent with the content of their conversation. For example, one psychologist described the effects of one client on professionals within her system of care and how knowing about her abuse history had informed a psychological formulation of her behaviour:

> *"helping them to understand, why she behaved like she did [...] she would make everybody very irritated and angry with her... in the system and kind of despairing [laughs] by her behaviour".*
>
> (Participant 1)

Secondly, psychologists also used laughter in a way which alluded to absurdity of a particular statement. For example, one psychologist made reference to the lack of any trauma training in her clinical training:

> *"If you go back to the [...] mid to late '80s, trauma was not talked about. PTSD was <u>unheard</u> of... [Laughs]".*
>
> (Participant 1)

Another psychologist made reference to attitudes, which may discourage qualified psychologists engaging in personal therapy:

> *"I think that there's this perception that once you're qualified, you're kind of sorted [laughs]..."*.
>
> (Participant 3)

Psychologists' use of laughter seemed to communicate a number of things in this study. Laughter conveyed a sense of amusement relating to irrational attitudes within the Clinical Psychology profession, a means of ameliorating the negative affect which may derive from psychologists' frustrations with the status-quo and to mask making statements that may gain disapproval from me or be regarded as politically incorrect.

3.1.4.5: Subcategory- Trying to Fit into the System

This subcategory links to the context in which these psychologists practice. The psychologists in this study described trying to work with CSA disclosures from clients while reconciling their work with the demands and restrictions placed on them within various systems. The systems that they felt most impacted on their work included the psychology service, the NHS, local non-statutory services for sexual abuse survivors and governmental policy. Psychologists discussed the issues within the psychology service which they felt had implications on their work with clients who disclose CSA.

This psychologist discussed potential areas for improvement within her locality service:

> *"we run an assessment clinic and treatment, there's a short wait for treatment sessions. I guess it just makes you think about the implications of all of that [asking about abuse in assessment] [...] we really need to be flexible about that, to see certain people and to do it differently".*
>
> (Participant 3)

Many psychology services in this health board have moved towards a *rapid assessment* approach. As waiting lists for psychology services have increased, rapid assessment has been used as an early screening approach to assess client suitability for psychological intervention and to triage clients towards appropriate services in a timely fashion.

This psychologist described the pressures of working within a rapid assessment model, particularly when CSA disclosures are made by clients:

> *"you're pulling somebody off the waiting list, you're meeting them on a one-off basis, you've got a limited time [...] personally, often I'm really glad if I find out say, that there was a cancellation of somebody afterwards or have gotten just before lunch or the end of the day so I've got a little bit more time and it takes all that pressure off".*
>
> (Participant 7)

The use of rapid assessment may mean that clients have to wait for the most appropriate service, which may influenced by the specific skills or gender of a psychologist within the team.

One psychologist discussed the potential importance of working with therapist gender and her team's attempts at accommodating client preferences:

> *"I guess especially with childhood sexual abuse, you know, in terms of service it's often the gender of the therapist".*
>
> (Participant 3)

Psychologists in this study were expected to balance large case-loads which impacted on their ability to see clients as frequently as they would prefer, particularly if they were at the point of CSA disclosure. One psychologist explained that the presence of local statutory outreach services and non-statutory services for abuse survivors was helpful in managing this:

> *"the wider... network of the NHS and voluntary organisations, you know and mental health services... and things like [names abuse survivor support service] as well, that can be really useful I think... knowing that there are other types of support, I think, I guess as psychologists, we are limited in what we can offer in terms of frequency of appointments [...] at least there are other people who are providing that, and that really helps".*
>
> (Participant 3)

Many psychology services now offer a maximum number of therapy sessions to service-users in order to maintain case turnover. Some psychologists felt that a restriction in sessions could be unsuitable when working with clients' during disclosures and described offering more sessions in order to complete therapy satisfactorily. However, one psychologist acknowledged the potential strain on resources and sense of personal pressure that could arise from "opening" clients up to talking about abuse:

> *"If you start thinking about that in terms of a whole service [...] and what would happen if you opened that up but didn't have the time or space or skills to deal with it, or other circumstances interfered, you know, you move practice, you move job or were ill, you couldn't get through that with that person [...]but, you know if the guidelines are to ask about traumatic events, then one of the consequences are that is that you then have to do something with that".*
>
> (Participant 7)

The psychology profession has developed within the health professions in the UK. Psychology has long since aligned itself with a 'bio-psychosocial' model of understanding mental health. However, this has not always sat comfortably within a health service where the dominant model assumes a bio-medical model of health (Evison, 2007). Psychologists in this study described their frustrations with understanding and working with the effects of CSA within this medically dominated system.

This psychologist describes such a tension:

> *"It* [CSA] *doesn't fit in anywhere, into anyone's diagnostics... it doesn't really fit yet the vast majority of the cases that I see, and most people probably, in adult mental health, the clinical psychologist [...] it's not a mental illness as such... so what is it?[...] it's a social problem, it's an emotional problem, it's trauma, it has an effect on developmental... it has an effect on every aspect of a person's development... or it <u>can</u> have... erm... and how do you fit that into a mental health system? It's not a diagnosable mental illness...[...] it's the vast majority of the work that we do and we work in an adult mental health service".*
>
> (Participant 4)

Indeed, a number of psychologists felt that survivors of childhood trauma were over represented within their service, with many seeing complex problems and childhood trauma as the norm in their work.

3.1.4.6: Subcategory- Experiencing Obstacles

Psychologists discussed their attempts to balance the pressures within the system whilst working with survivors. Some of the obstacles which psychologists faced involved creating a safe therapeutic space to encourage and work with CSA disclosures:

> *" rushing from clinic to clinic, demand for numbers... and not having, [...] an office, it's a space, you can create a nice space for somebody to come into... that's quite containing in itself. I think when you're going out to clinics, GP surgeries, different rooms, you have to create it very much in the relationship yourself, there's nothing else to help you with that, it has to be done quite intensively in that therapeutic relationship [...] I think it makes it more difficult, I think it creates more stress as a therapist certainly, you know having to rush there, and the time that you have with the client and the space around it".*
>
> (Participant 1)

Another described inadequate clinic rooms as "dodgy" and non sound-proofed, with potentially distressing effects on clients. She illustrated this issue by referring to her work with a specific client:

> *"I work with her in a room that's got a couple of posters, which are quite triggering for her and I have to keep remembering to take them down [...] and then I've got to put them back up again, because there's somebody else who uses that room wants them up there".*
>
> (Participant 7)

Pressures within the work system were described as an obstacle to self-reflection and peer support:

> *P8: "yeah, I suppose it's trying to think and get advice and the problem is that you don't often have a lot of space to think... either in the session or out with"*
>
> ***ER: "So what might be causing that lack of space?"***
>
> *P8: "Too much to do [laughs] too many people to see, you know just time pressure, erm yeah... bureaucracy [laughs]".*

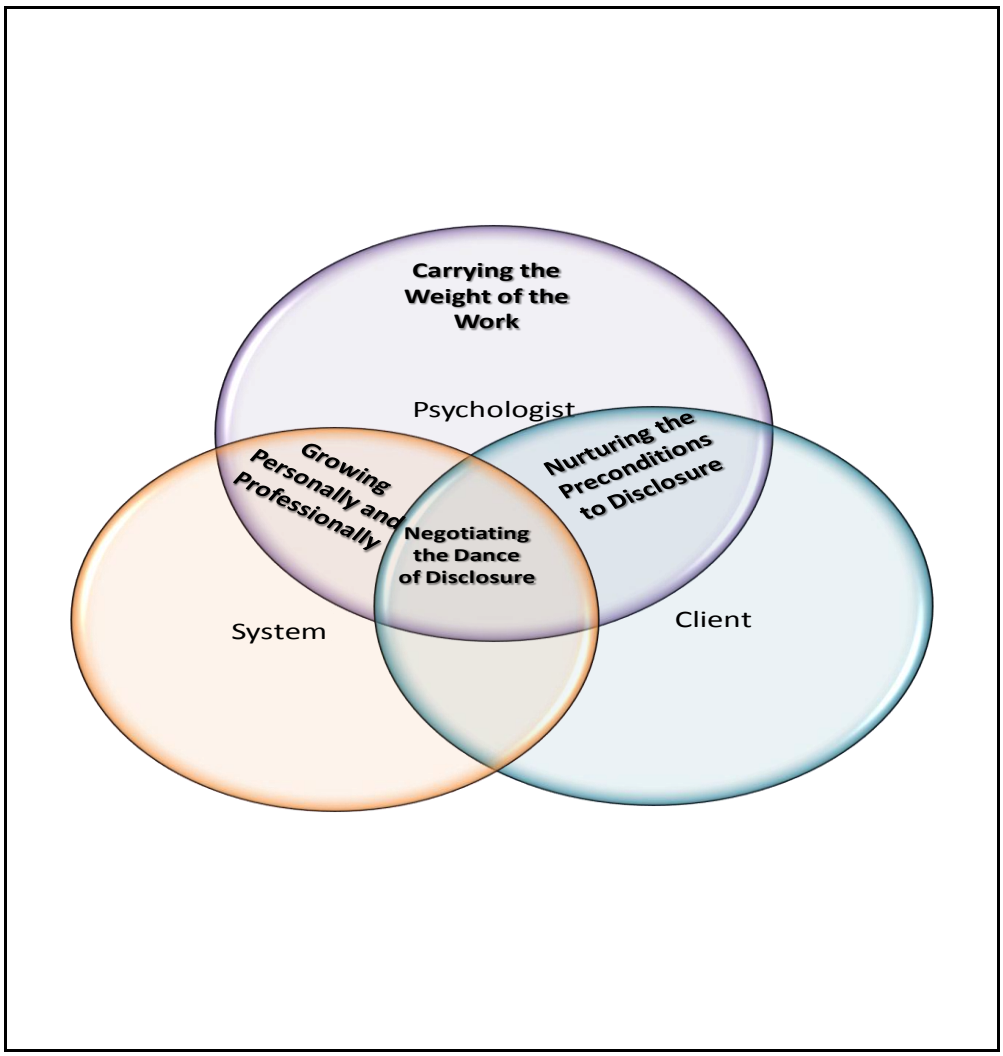
Psychologists described competing with multiple pressures, whilst managing their own expectations in working with survivors:

> *"people start cutting those kind of over- unrealistic expectations of themselves... erm... and once you do that it does put erm... pressure on completing everything and I think there is a tension".*
>
> (Participant 7)

The accounts of psychologists within this study correspond with the evidence that professionals find CSA disclosures from clients as emotionally challenging (Chouliara, *et al*. 2010, *Under Review*; Frenken & van Stolk, 1990). However, unlike previous research, which has demonstrated that psychologists avoid talking about abuse or dissuade disclosures (Nelson, 2009; Nelson & Phillips, 2001; Young, Read, *et al*. 2001; Frenken & Van Stolk, 1990); psychologists within this study expressed a wish to cultivate the conditions to encourage disclosure and a readiness to encourage talk about abuse and manage the personally emotional impact of doing so.

3.1.5: A Grounded Theory Model of Psychologists' Experience of CSA Disclosure in Clinical Practice- Negotiating the Dance of Disclosure

Figure 12. A Theoretical Model of Negotiating the Dance of Disclosure



This study proposes a model which accounts for psychologists' experiences of CSA disclosure in clinical practice (figure 12). Few psychologists described experiencing CSA disclosures from clients in a way that was spontaneous or had been presented to them in a referral letter. A more common experience for psychologists in this study involved a process of disclosure, which was neither predictable nor followed a specific set of stages. Rather, the process of disclosure is described as a "dance", which is regulated and paced by the psychologist who attempts to become attuned to

the client within the specific therapeutic relationship and adjusts the pace of the work accordingly. Each dance is unique and is shaped by the relationship between client and psychologist, the psychologists' own cumulative experiences of previous disclosures and the systems in which the dance occurs. In the dance of disclosure, the psychologist must remain present, and engaged with the client in order to provide a reparative experience to the client's disclosure.

Psychologists learn and develop ways of nurturing the preconditions for each dance to take place, which become integrated into their set of therapeutic skills and psychological knowledge. They become more skilled in nurturing the preconditions to the disclosure process which consist of a safe and therapeutic relationship, the ability to contain the client's emotions and an ability to talk about abuse and a capacity to maintain a dual awareness of the client and also their own reactions to the work. The ability to nurture these conditions feeds into the dance and informs the dances which occur in the future.

The experiences of the dance have a positive impact on psychologists allowing them to grow personally and professionally. Accordingly, psychologists learn and enhance their work and skill, this is termed: growing personally and professionally. Areas of growth involve the ability to engage with external supports whilst cultivating self-awareness to develop increasing competency. Psychologists felt privileged by clients' invitations to work with them through their disclosure. This then feeds back into every subsequent dance that the psychologist leads. Psychologists must present this part of themselves in the dance, while keeping another part of them hidden from view. These hidden aspects are the effects of carrying the weight of the work, with which the psychologists must contend. This involves: coping with anxiety, feelings of responsibility, an awareness of risk whilst protecting themselves and trying to undertake the work within a number of complex systems. In managing this, the psychologist attempts to keep this from intruding into the dance and the ability to nurture the conditions to disclosure.

3.2: Research Diary

The use of a research diary was important in analysing participants' narratives. Through careful diary-keeping, reflecting on my own experiences of interviews and during transcription, I was able to gain insight into the concerns and anxieties expressed by the psychologists within the study.

Many psychologists reported having no training in disclosure and inquiry work. The psychologists who had been qualified for the longest length of time reported having no training in working with CSA issues in their pre-qualification training. Rather, psychologists' training had been largely self-directed, with attendance at the occasional workshop or seminar. Parallel to this, clinicians seemed increasingly aware of the policies and recommendations, which aim to improve inquiry practices amongst mental health professionals to benefit service-users.

These issues emerged as I analysed my research diary. Doing so helped me focus on interviews where I had perceived a level of discomfort from the participant. This generated further exploration into the emotional experiences of psychologists and how this may have impacted upon the 'reality' constructed within our discussions. These issues fell into four broad themes: anxiety, metaphor, hazard and reflecting on my own reactions.

3.2.1: Anxiety

This section came from an early diary entry:

> ***"noticed feeling rather anxious during this interview- strange. I get the impression that [she] was thinking 'why are you asking me this? It's basic stuff!'. Uncomfortable, [I'm] worried that nothing original is going to come up here [...] was [she] uncomfortable/ steering clear of criticism? Felt like a rather empty interview".***
>
> December '09

This helped me to reflect on the potential scrutiny that participants may have felt during interviews. Although I had not set out to evaluate or scrutinise psychologists (particularly not my colleagues), this was happening and I *was* responding to my

judgements about the views of participants. I suspect that this may have influenced what psychologists may have felt more confident in saying, potentially influencing their laughter and use of metaphor.

Another entry was completed following an interview where one participant told me that they had tried to be honest, but aware that she would also be trying to offer "the right answer":

> ***"I commend [her] honesty about trying to be open with me, yet wanting to say 'the right answer'[...] such an eye-opener! Someone so experienced and confident in their practice but still worried/ anxious about getting it wrong [...] this concern about getting it wrong- does it ever go away?"*** January '10

This reflection allowed me a greater confidence in asking directly about these feelings with participants in subsequent interviews. This sense of 'coping with the unknown' was interesting to me, particularly its presence, despite the experiences and skills of these psychologists. It made me wonder: if psychologists feel anxious about it, how do other workers find working with inquiry and disclosure?

> ***"...I am all too aware of how people respond to CSA disclosures seems a vital point where, the wrong, uncaring or simply inappropriate response to disclosure can set someone back on their journey. It is interesting then, that we are asking so many front-line workers to routinely inquire into this stuff..."*** November '09

Analysis of results demonstrated to me that negotiating the disclosure process is a highly complex and skilled process, which occurs parallel to the therapeutic process. Psychologists reported their attempts to manage these complexities within the various systems which surround them and the client. How does this complex process translate to front-line workers who are also required to ask about abuse (e.g. in A&E and sexual health departments) and how prepared do they feel in managing CSA disclosures?

3.2.2: Metaphor

This theme referred to my reflections on participants' uses of metaphor and the underlying meanings that I felt this might convey:

> ***"Metaphors! Again! They seem to convey so much. I am using metaphors too- I can't remember using them, but they're there, in the transcripts. Why do we need to use metaphor? Is this something too complex, something so emotionally charged that we need to use metaphors?! [...] are we distancing ourselves from that emotional charge?"*** January '10

In comparing the use of metaphor within the research interviews with the function of metaphor within the relevant literature, I was able to construct the sub-category: *protecting myself*, referring to the psychologist's management of the difficult emotions that they felt towards survivors and CSA disclosure.

3.2.3: Hazard

This refers to the implications of caution and danger, and my reactions to this theme:

> ***"There is this sense of toxicity regarding survivors. That their experience/ their trauma can in some way be transmitted [...] although the impact of clinical work must be taken seriously, the concept that survivors' narratives may in some way be hazardous is difficult for me".*** December '09

> ***"Avoiding the "nitty-gritty"- again there is this sense of caution. Echoed by other participants in statements such as "you've got to be careful". Who are they being careful for? Themselves, the survivors? Or both?"*** January '10

These reflections helped me to develop my questioning in subsequent interviews to investigate these issues further.

3.2.4: Reflecting on my own reactions

This theme refers to my reflection on emotions experienced during interviews:

> ***Today I interviewed a colleague. I noticed feeling angry [...] she referred to how being a survivor of CSA undermines one's ability to work as a psychologist. I don't feel undermined by surviving abuse!***
>
> December '09

This entry allowed me to reflect on my sense of needing to defend myself against views, which seemed extant within the Clinical Psychology profession. However, if this represents a belief that is held by psychologists then this is likely to influence the extent to which a psychologist may feel able to reflect openly on their own experiences and attitudes about abuse (survivor or not), which may continue throughout their career unless they perceive a more supportive and open ethos from peers. This attitude may also maintain implicit attitudes regarding the survivor-therapist's capacity to make use of supports within the system. Further, an attitude expressed by another participant of 'just deal with it' concerning a psychologist's discomfort in working with abuse may compromise a clinician's ability to admit difficulty if this is not mediated by an encouragement to discuss difficulties openly.

4: Reflections

This section will begin with a summary and reflection on the current study and the new insights which were constructed. The researcher's reflections regarding the research process will then be discussed. Following this, the implications of the results for theory and clinical practice will be considered. This chapter will conclude with a critique of this study.

4.1: Summary of the Research

This study constructed a Constructivist Grounded Theory of clinical psychologists' experience of childhood sexual abuse disclosures from clients in Adult Mental Health and the impact of disclosure and inquiry on psychologists in clinical practice. A theoretical model was constructed to account for the disclosure process or 'dance' which is negotiated between the psychologist and client. In this dance, the psychologist must keep the client within a therapeutic window, whilst remaining receptive to opportunities to encourage disclosure for the benefit of the client.

The extent to which the psychologist can nurture the preconditions to disclosure depends on an interaction between the client, psychologist and the system. The psychologist's ability to do this is mediated by two factors: their ability to manage or 'carry' the weight of the work and a transformation through personal and professional growth. Both carrying the weight of the work and growing personally and professionally have different weightings depending on the unique factors relating to the psychologist, the client and the supportiveness of the system.

Carrying the weight of the work is linked to existing theories regarding the negative effects of working with emotionally demanding jobs and specific work relating to treating survivors of trauma, which fall under the umbrella term: Secondary Trauma.

4.1.1: What does the research tell us about Burnout and Secondary Trauma?

Burnout

This 'normative' response to the impact of long-term emotional exhaustion is characterised by depersonalisation and a diminished sense of personal accomplishment (Maslach *et al.,* 2001). While the concept of burnout had a resonance within psychologists' narratives, there did not seem to be a marked presence of all three symptoms which would be suggestive of the most extreme form of burnout (Schaufeli *et al.,* 1993).

The categories of carrying the weight of the work and nurturing the preconditions to disclosure demonstrated the impact of a demanding job with competing roles. Psychologists have high levels of responsibility for the well-being and safety of their clients and the general public. This was demonstrated by subcategories relating to feeling responsible and managing the unknown. There was a high level of concern expressed by psychologists about "getting it right" despite there being no correct answer. Frustration was expressed by psychologists regarding inadequate resources such as office space and poor clinic rooms. Psychologists were also under pressure to balance an increasing amount of direct client-related work, with little time to reflect on this whilst adhering to bureaucratic NHS systems.

Psychologists were aware of risks associated with becoming desensitised to CSA and disclosure due to the sheer number of survivors that they worked with in clinical practice. Overcoming the taboo of discussing CSA happens with increasing clinical experience, which is an essential component of working with adults who have experienced abuse. However, psychologists were aware of the need to balance this with emotional engagement with the client, so their discussion of the topic would not seem *flippant*, blasé or shocking to the client. The view that emotional engagement is a mediator against depersonalisation seems to be implicated here (Maslach, et al., 2001). However, as many psychologists within this study commented, emotional engagement requires a balance in order to achieve 'accurate' empathy.

As discussed in chapter 1, burnout is associated with the emotional demands within the workplace, rather than being a reaction to trauma. The role of the system in which psychologists work was considered by participants to contribute to their frustration and stress levels within the job. In the burnout research, higher levels of emotional exhaustion have been shown in psychologists who have less autonomy over their work, who work longer hours and spend greater amounts of time spent taking care of paper work and other administrative tasks (Rupert & Morgan, 2005). Subsequent research placed Australian clinical psychologists at a higher risk of burnout if they worked within statutory mental health settings (Emery, et al., 2009).

The general tenet regarding burnout is that it is a response to overload (Maslach, et al., 2001). This has been linked in the literature to job characteristics (i.e. too much to do and too little time to do it in) and the strain of managing competing workloads. In addition to the demands of the job, burnout has been associated with level of social resources present in the work system. Social support in the work of clinical psychologists relates to a number of aspects, including clinical supervision and peer support networks.

Vicarious Traumatisation and Compassion Fatigue

The distinction offered by researchers between vicarious traumatisation and secondary traumatic stress relates to either belief change (VT) or symptom development (CF) resulting from work with survivors of trauma. There was some overlap between participants' narratives and symptoms of secondary traumatic stress symptoms. This seemed to fit with psychologists' accounts of "carrying around clients" with them, particularly if these clients had disclosed a form of child abuse to them. "De-briefing" was seen as an important way of managing this through contact with peers and within supervision. Participants warned against "going home with these thoughts". It appears that psychologists within this study are watchful for indications of intrusion which may relate to the concept of Compassion Fatigue, where the individual 're-experiences' the client's traumatic experience through thoughts or imagery (Figley, 2002). However, the experiences of psychologists in relation to hearing CSA disclosures did not indicate a pervasive presence of all three

core characteristics of CF: psychological avoidance, hyperarousal and intrusive thoughts.

Psychologists did make explicit reference to vicarious traumatisation relating to their work with survivors. For instance, comments such as the work making them witness *"man's inhumanity to man"* and being exposed to the *"awful stories"* of childhood sexual abuse were associated with an acknowledgement of the risks associated with trauma work and the need to be careful that it does not impact on their own core beliefs.

This also linked to the concept of the psychologist's "own stuff" such as the core beliefs, shaped by their life experiences, which they felt may place them at risk of VT and burnout. For instance, one psychologist felt that she needed to remember that she could be a *"self-sacrificer"* and *"subjugator",* indicating that she might put the needs of others above their own and at risk of vicarious trauma and burnout. Yet again, supervision was seen as having a mediating effect on the psychologist's vulnerability to secondary trauma, and so too was personal therapy. A number of surveys amongst therapists have demonstrated that the most helpful coping strategies have been described as seeking support from others, being supported by peers, using clinical supervision, training and personal therapy (Hollingsworth, 1993; Schauben & Frazier, 1995). In relating this to the results from the current study, psychologists appeared to actively engage in supportive strategies which they felt protected them from the effects of vicarious trauma.

4.1.2: What does the research tell us about Personal and Professional Growth?

This study offered new insights into the impact of experiencing CSA disclosures from clients. The category "growing personally and professionally" demonstrated that the work had a positive and transformational impact on psychologists who described feeling privileged by a client's choice to disclose abuse to them and a sense of growing competencies in therapeutic skill, knowledge and self-awareness. This then feeds back into the psychologist's work with clients and enhances other

roles as supervisor and manager of other psychologists and their work within multidisciplinary teams.

This sense of growth coming from exposure to clients' narratives of trauma appeared to relate to a recent concept which terms the positive impact of working with trauma as *'vicarious resilience'* (Hernandez *et al.,* 2007). This concept was developed from a phenomenological study into 12 psychotherapists working with survivors of political violence and kidnap. Vicarious resilience refers to the therapist's interaction with the client's narratives of resilience through an empathic connection. This involves witnessing the resilience of the client and reflecting on the therapist's own problems and resilience. This in turn affects therapist schemas of self and other, influencing how they interact with the world around them. The evidence to support the theory of vicarious resilience is still in its infancy, however a subsequent qualitative research study (using grounded theory) with 10 clinicians working with survivors of torture also demonstrated a profound and positive schema shift, that clinician's own resilience was improved and their work with clients was highly valuable to them (Engstrom *et al.,* 2008).

4.2: Reflections on the Research Process

Given my level of personal and professional involvement with this study and topic, an ability to reflect upon the research process was vital. This practice is highly supported within the Constructivist Grounded Theory methodology (Charmaz, 2006). The personal involvement in which the interviewer has placed in a specific area of research has been seen as important aspect of commitment to the phenomenon under investigation, and even crucial to avoid missing important information or investigating irrelevant issues (Gubrium, 1994; Yardley, 2000). As demonstrated throughout this thesis, I have a strong involvement with this subject area. The process of reflection emphasised the unique interaction of multiple roles in carrying out this research. As a researcher studying psychologists' work with CSA survivors, I have been able to draw from my own experiences of working therapeutically with survivors as a Specialist Psychological Practitioner within clinical psychology training. I have also drawn from my experience of being a

survivor of CSA and experiences of personal therapy. I think that this combination of roles has helped me to be sensitive to both understanding the narratives of psychologists and being able to think critically about the views and attitudes expressed at interviews, informing my analysis and helping it to resonate with readers, mental health professionals and survivors alike.

Examples of this critical analysis have involved reflecting on my own feelings, thoughts, appraisals and beliefs in response to participant interviews. For instance, as demonstrated within analysis, there was a noticeable absence of discussions of male clients. This was highlighted by the memo "**Where are all the men?"** where I considered the literature relating to male survivors of abuse. As discussed in Chapter 1, males as survivors are underrepresented within the literature (Holmes & Offen, 1996). However, research has consistently shown that there is a need for CSA support services for males (Nelson, 2009; Sorsoli *et al.,* 2008).

The only reference made by any participant to male survivors occurred when asked what reasons they felt may cause a psychologist not to ask about CSA with a client. Their suspicion was that that some may avoid asking a "*man's man*" (Participant 6) who may be too guarded to discuss such issues in therapy. Stereotyped beliefs have been implicated in a professional culture which promotes *"the feminization of victimization and the masculinisation of perpetration"* (Spiegel, 2003, p. 15). This supports the evidence, which suggests that client gender can influence a psychologist's consideration of CSA (Lab *et al.,* 2000; Holmes & Offen, 1996). It may be that client gender influences the disclosure process, to the way in which the psychologist grasps, responds to and encourages disclosures of CSA from male clients.

I found it unlikely that no psychologists within this study had any recent experience of CSA disclosure from men and hypothesised that this demonstrated a difficulty even today in seeing males as victims of abuse. Further, the recruitment of male participants within this study was also interesting to me. Male psychologists are a minority within this health board, reflecting the general underrepresentation of males within the Clinical Psychology profession; however this has caused me to question why more males did not respond to my invitation to participate within this study.

There is evidence to suggest that male psychologists believe that CSA is less common than female psychologists (Gore-Felton *et al.,* 1999; Holmes & Offen, 1999; Lab *et al.,* 2000). This may support the view that men were less likely to regard this research study as relevant or interesting to them.

I have also reflected on my use of participant quotes throughout the analysis. I have endeavoured to represent a balanced view of participant's narratives for all voices to be heard. I must acknowledge however, that the views and experiences of some participants resonated with me more than others. I was aware of a sense of gratitude that I felt towards participants who demonstrated opinions that I agreed with and was drawn to those with less pejorative attitudes about therapist-survivors and working with clients that have been abused in childhood. My frustrations lead to a sense of dread when participant's revealed views that I felt were out-dated or professionally disappointing. However, it is important to acknowledge the level of trust that was placed in me as a researcher by participants to be able to openly express feelings that they may have otherwise kept hidden, and at times this was difficult for me to reconcile with my roles as critical researcher, survivor and colleague. I have attempted to resolve this by deliberately giving a voice to narratives that did not resonate with me. In offering a commitment to this study, I have attempted to keep a balance by including and not shying away from the narratives that were at times, uncomfortable to hear.

A further reflection concerns the issue of routine inquiry into abuse amongst health professionals. As detailed within chapter 1, there has been a recent shift towards health policies advocating the use of routine inquiry into all forms of abuse by members of frontline health service and mental health staff, with all service-users. When I started this project, I felt very strongly in favour of routine inquiry of abuse in mental health and general health services. However, as this study progressed I became aware of the complexity involved in the processes of inquiry and working with disclosure for clinical psychologists. Although this may not necessarily reflect the experiences of other staff members, who undertake different roles with (possibly) different clients, I am less convinced that routine inquiry would necessarily be helpful to everyone.

Given the complexity of experience and the issues which influenced psychologists' response to CSA disclosure, I wonder in what way routine inquiry will affect both clients of all health services and the members of staff. This will have implications for how staff members from other professional backgrounds approach the delicate issue of a client's childhood abuse and then raises the question, to what extent do we permit people to be the gate-keepers of their own experiences? Clearly there will be implications in the continuous support of staff members expected to undertake such a task and some research addressing the experience of routine inquiry amongst other staff groups and users of these services is necessary.

The notion that working with survivors can be a positive experience of growth for psychologists resonates with me. Throughout my clinical training, I have witnessed clients display great amounts of resilience, from even the most deprived and abusive of early environments. The concept that Vicarious Resilience may positively alter psychologists' beliefs and behaviour is an interesting concept and provides a balance to the Secondary Trauma literature. Further, this concept has substantial implications for enhancing clinical practice and further research into this area is required.

4.3: Implications of the Results

The construction of a grounded theory about psychologists' experiences of CSA disclosure and working with survivors has been able to highlight a number of implications for clinical practice and future research which were embedded in the views and experiences expressed by psychologists.

4.3.1: Implications for Clinical Practice

Training

A number of issues relating to training were discussed by participants. Psychologists found training in psychological therapies which contained 'developmental needs-based' and relational models influenced their work with survivors. They also found a broad knowledge of issues relating to CSA, sequelae and prevalence helpful in their work and felt that demonstrating a greater knowledge of such issues gave them

credibility in the eyes of their clients and greater confidence as a result. It was felt by many participants that therapeutic knowledge and skills could be taught alongside information that has specific relevance to CSA at pre-qualification level and throughout continuing professional development.

Practical training is at the very heart of clinical psychology training. Pre-qualification training placements are likely to guarantee a trainees experience of working with CSA survivors (if they have not already). These will be important learning experiences which need to be supported within the context of a good supervisory relationship where the trainee can begin to reflect on difficult emotional experiences such anxiety about getting everything right, and is likely to prepare them for qualified practice.

Supervision and Support

Given the weight that psychologists gave to supervision, there are significant implications for what might be considered "good practice" here. Generally, supervision was found helpful when it allowed a safe space where psychologists could reflect on their feelings about particular clients or specific issues whilst being able to problem-solve and seek advice when needed. Social support is seen to act as a "buffer" against burnout (Maslach et al. 2001). In Harrison and Westwood's (2009) narrative analysis of trauma therapists' coping strategies; therapists felt that supervision reduced professional isolation; provided an environment in which they could self-reflect and self-monitor thoughts and emotions and implement self-care strategies. Peer contact was seen to offer a supportive environment where therapists could learn effective coping strategies and encourage each other to recognise indications of burnout or vicarious traumatisation within a safe group support network. This bears significant implications for how mental health systems encourage workforces to access support which is most helpful to the individual practitioner.

Psychologists within this study spoke at length about the importance of both clinical supervision and access to support from professional peers. Both provided the

opportunity for psychologists to discuss and work through their uncertainties about the work. Further, this support seemed to be particularly linked to 'normalising' psychologist's anxiety, freeing them up to reflect on work with specific clients. This has implications in not only how as a profession we have learned to support our professional peers, but also how this can be extended to other professional groups who encounter CSA disclosure and have less access to supervision and continuing professional development within their work.

Self-reflective Practice and Personal Therapy

A further implication for practice involved self-reflection and personal therapy. Participants felt that historically, the clinical psychology profession has discouraged its members from openly discussing distress or difficulties resulting from the work. One example of this was considered to relate to the fact that clinical psychologists are not encouraged to access personal therapy as part of continuing professional development, whereas it is a professional requirement for accreditation in training models such as counselling psychology and psychoanalytic psychotherapy (Grimmer & Tribe, 2001).

Many participants felt that this culture was slowly breaking down in favour of a more open ethos amongst psychologists. One participant explained that an ability to discuss these issues safely and openly needed to be *"kept on the agenda"* by teams at all times for it not to be overtaken by more pressing business. The role in which supervisors and managers can play in the working culture was discussed with implications for this to be modelled by those in greater positions of power. This may serve to encourage more psychologists to consider personal therapy as another aspect of self-care.

Research

The results of this research demonstrated that psychologists encountered many risk factors for burnout and vicarious traumatisation in their work with survivors and their experiences of working with CSA disclosure. However, psychologists identified

a number of factors within this work that they regarded as protective and even transformational in their personal and professional lives. As yet, the empirical evidence regarding factors that mediate against the weight of the work is limited. Research into the factors which can counteract the negative impact of the work and optimise vicarious resilience is warranted for future exploration.

The extent to which this grounded theory reflects the experiences of other psychologists out with this occupational system is unknown and further study into this would be implicated. Further, this also prompts the question: to what extent does it reflect the other side of the disclosure experience in clients' narratives? Some further research into these issues would be valuable additions to the results of the current study.

4.4: Critique

To the author's knowledge, this is one of the first studies to explore psychologists' experiences of hearing CSA disclosures from clients. Therefore this study addressed a number of gaps and limitations, which were apparent in previous research studies. This study used a robust and sensitive method of research, which was appropriate for study of this topic and professional group and offered a source of rich and useful data. The choice of a Constructivist Grounded Theory approach was justifiable and allowed the demonstration of a transparent and reflective research process.

Despite its strengths, this study did demonstrate limitations. Specifically, although data on gender and length of practice were collected, I did not collect information on the theoretical orientation of psychologists. Research has demonstrated that such factors influence therapists' personal attitudes and clinical judgements about survivors of CSA. For instance, one study found that female therapists who practiced using a psychoanalytic theoretical orientation were less inclined to believe allegations of sexual abuse than therapists with other theoretical orientations, whereas another found that behavioural therapists were less likely to believe that CSA was as prevalent as the literature suggests (Gore-Felton *et al.*, 1999; Tabachnick & Pope, 1997).

As this study did not seek to achieve generalisability of results, the theoretical interaction between psychologist, client and system is likely to be unique to psychologists working within this organisational structure. Although issues relating to the weight of the work and the psychologists' frustrations with the predominant medical model of health may reflect wider views of psychologists, it is not possible to predict the results of a study such as this within a different organisational context with differing degrees of professional isolation and a greater diversity of skills-mix.

Another potential limitation was that I did not actively seek to find psychologists who *did not* ask about sexual abuse with their clients. The purpose of the research study was transparent, and the participant information form made it clear that the intentions of the study were to investigate psychologists' experiences relating to abuse disclosures. Given the high profile nature of recent moves towards improving services for CSA survivors and routinely asking about abuse, this may have only attracted participation from psychologists who felt confident that their own practice was in keeping with current policies (Scottish Executive, 2005; Scottish Executive, 2008). Although some psychologists reported not asking routinely about abuse, explicitly sampling psychologists who did not discuss CSA with clients or those who avoided talking about abuse would have added an interesting dimension to this study, potentially constructing very different realities.

4.5: Concluding Remarks

The present study constructed knowledge about psychologist's experiences of hearing disclosures of CSA from clients in Adult Mental Health. This knowledge contributed new insights into the complex nature of the psychologist's role within the disclosure process and knowledge about the positive and negative impacts of hearing disclosures. The qualitative methodology has yielded rich and in-depth information about the experiences, meanings and feelings that psychologists experience when hearing disclosure and encouraging the client to disclose. This would not have been accessible using quantitative methodology. Obtaining this new perspective on disclosure has important implications for clinical practice and supervision.

References

Adams, S. A. and S. A. Riggs (2008). An exploratory study of vicarious trauma among therapist trainees. *Training and Education in Professional Psychology 2(1)*, 26-34.

Agar, K. and J. Read (2002). What happens when people disclose sexual or physical abuse to staff at a community mental health centre? *International Journal of Mental Health Nursing 11(2)*, 70-79.

Agar, K., J. Read, Bush, J.M.. (2002). Identification of abuse histories in a community mental health centre: The need for policies and training. *Journal of Mental Health 11*(5), 533-543.

Alaggia, R. (2004). Many ways of telling: expanding conceptualizations of child sexual abuse disclosure. *Child Abuse & Neglect 28(11)*, 1213-1227.

Andrews, G., J. Corry, Slade, T., Issakidis, C. & Swanston, H. (2004). Child Sexual Abuse. *Comparative quantification of health risks: global and regional burden of disease attributable to selected major risk factors.* In M. Ezzati, A. Lopez, A. Rodgers and C. J. L.Murray (Eds). Geneva:World Health Organisation, (pp1851-1940).

Arata, C. M. (1998). To Tell or Not to Tell: Current Functioning of Child Sexual abuse Survivors who Disclosed their Victimization. *Child Maltreatment 3(1)*, 63-71.

Babiker, I. E. (1993). Managing Sexual Abuse Disclosure by Adult Psychiatric Patients- Some Suggestions. *Psychiatric Bulletin 17*, 286-288.

Baker, A. W. & Duncan, S. P. (1985). Child sexual abuse: A study of prevalence in Great Britain. *Child Abuse & Neglect 9(4)*, 457-467.

Banister, P., Burman, E., Parker, I. Taylore, M. & Tindall, C. (1994). *Qualitative Methods in Psychology: A Research Guide.* Philadelphia: Open University Press.

Barnes-Holmes, Y., Barnes-Holmes, D., McHugh, L. & Hayes, S. C. (2004). Relational Frame Theory: Some Implications for Understanding and Treating Human Psychopathology. *International Journal of Psychology & Psychological Therapy 42(2)*, 355-375.

Bazeley, P. (2007). *Qualitative Data Analysis with NVivo.* London: Sage.

Beitchman, J. H., Zucker, K. J., Hood, J. E. da Costa & G. A. Akman, D. (1991). A review of the short-term effects of child sexual abuse. *Child Abuse & Neglect 15(4)*, 537-556.

Berlin, R. M. & Olson, M. E. (1991). Metaphor and psychotherapy. *American Journal of Psychotherapy 45(3)*, 359-367.

Berry, R. & Sellman, D. (2001). Childhood adversity in alcohol and drug dependent women presenting to outpatient. *Drug and Alcohol Review, 20*, 361-367.

Bowlby, J. (1988). A *secure base: Clinical applications of attachment theory*. London: Routledge.

British Psychological Society (2007). *New Ways of Working for Applied Psychologists in Health and Social Care – Organising, Managing, and Leading Psychological Services.* Leicester: Author.

British Psychological Society (1995). *Professional Practice Guidelines: Division of Clinical Psychology*. Leicester: BPS.

Bradley, R. G. & Follingstad, D. R. (2001). Utilizing disclosure in the treatment of the sequelae of childhood sexual abuse: A theoretical and empirical review. *Clinical Psychology Review 21(1)*, 1-32.

Briere, J. (2002). Treating adult survivors of severe childhood abuse and neglect: Further development of an integrative model. *The APSAC handbook on child maltreatment*. In J. E. B. Myers, Berliner, L., Briere, J., Hendrix, C. T., Jenny, C., Reid, T. A. (Eds). Thousand Oaks: CA, Sage (pp. 175-203).

Briere, J. & Runtz, M. (1988). Symptomatology associated with childhood sexual victimization in a nonclinical adult sample. *Child Abuse & Neglect 12(1),* 51-59.

Browne, A. & Finkelhor, D. (1986). Impact of child sexual abuse: a review of the research. *Psychological Bulletin 99(1),* 66-77.

Bryer, J. B., Nelson, B. A., Miller, J. B. & Krol, P. A. (1987). Childhood sexual and physical abuse as factors in adult psychiatric illness. *American Journal of Psychiatry 144(11)*, 1426-1430.

Bryman, A. (2004). Interviewing in Qualitative Research. *Social Research Methods.* New York: Oxford University Press.

Cavanagh, M., Read, J. & New, B. (2004). Sexual Abuse Inquiry and Response: A New Zealand Training Programme. *New Zealand Journal of Psychology 33(3*), 137-144.

Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis.* London: Sage.

Chouliara, Z., Karatzias, T., Scott-Brien, G., Macdonald, A., MacArthur, J. & Frazer, N. (*Under Review)*. Talking Therapy Services for Adult Survivors of Childhood Sexual Abuse (CSA) in Scotland: Perspectives of Service Users and Professionals.

Chouliara, Z., Hutchison, C. & Karatzias, T. (2009). Vicarious traumatisation in practitioners who work with adult survivors of sexual violence and child sexual abuse: literature review and directions for future research. *Counselling & Psychotherapy Research 9(1)*, 47-56.

Clearing House for Postgraduate Courses in Clinical Psychology (2008). Retrieved July 2010 from http://www.leeds.ac.uk/chpccp/.

Coker, A. L., Smith, P. H., Thompson, M. P., McKeown, R. E., Bethea, L., Davis, K. E. (2002). Social support protests against the negative effects of partner violence on mental health. *Journal of Women's Health & Gender-Based Medicine, 11(5)*, 465-476.

Cole, C. (1988). Routine comprehensive inquiry for abuse: A justifiable clinical assessment procedure? *Clinical Social Work Journal. 16(1)*, 33-42.

Collins, S. & Long, A. (2003). Working with the psychological effects of trauma: Consequences for mental health-care workers: A literature review. *Journal of Psychiatric and Mental Health Nursing 10(4)*, 417-424.

Craine, L. S., Henson, C. E., Colliver, J. A. & MacLean, D. G. (1988). Prevalence of a history of sexual abuse among female psychiatric patients in a state hospital system. *Hospital & Community Psychiatry*. *39(3)*, 300-304.

Creswell, J. W. (2003). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches.* Thousand Oaks, CA: Sage Publications.

Cunningham, J., Pearce, T. & Pearce, P. (1988). Childhood sexual abuse and medical complaints in adult women. *Journal of Interpersonal Violence 3(2)*, 131-144.

Day, A., Thurlow, K. & Woolliscroft, J. (2003). Working with childhood sexual abuse: a survey of mental health professionals. *Child Abuse & Neglect 27(2)*, 191-198.

Denov, M. S. (2003). To a safer place? Victims of sexual abuse by females and their disclosures to professionals. *Child Abuse & Neglect 27(1)*, 47-61.

Despland, J., Bernard, M., Favre, N., Drapeau, M. De Roten, Y. & Stiefel, F. (2009). Clinicians' defences: An empirical study. *Psychology & Psychotherapy: Theory, Research & Practice 82(1)*, 73-81.

DiLillo, D. & Damashek, A. (2003). Parenting Characteristics of Women Reporting a History of Childhood Sexual Abuse. *Child Maltreatment 8(4)*, 319- 333.

Doll, L. S., Joy, D., Bartholow, B. N., Harrison, J. S., Bolan, G., Douglas, J. M., Saltzman, L. *et al.* (1992). Self-reported childhood and adolescent sexual abuse among adult homosexual and bisexual men. *Child Abuse & Neglect, 16 (6)*, 855-864.

Drake, B. & Zuravin, S. (1998). Bias in child maltreatment reporting: Revisiting the myth of classlessness. *American Journal of Orthopsychiatry 68(2)*, 295-304.

Draucker, C. B. & Petrovic, K. (1996). Healing of adult male survivors of childhood sexual abuse. *Journal of Nursing Scholarship 28(4)*, 325-330.

Emery, S., Wade, T. & McLean, S. (2009). Associations among therapist beliefs, personal resources and burnout in Clinical Psychologists. *Behaviour Change 26(2)*, 83-96.

Engstrom, D., Hernandez, P. & Gangsei, D. (2010). Vicarious Resilience: A qualitative investigation into its description. Traumatology, 14(3), 13-21.

Everill, J. & Waller, G. (1995). Disclosure of sexual abuse and psychological adjustment in female undergraduates. *Child Abuse & Neglect 19(1)*. 93-100.

Evison, R. (2007). A New Deal for Survivors of Childhood Sexual Abuse. *British Psychological Society: Scottish Branch Bulletin* 32(Summer), 4-9.

Figley, C. R. (2002). Compassion Fatigue: Psychotherapists' chronic lack of self care. *Journal of Clinical Psychology 58(11)*, 1433-1441.

Fink, P., Read, J., Dawes, R. M., Kihlstrom, J. F., McNally, R. J., Loftus, E. F. *et al.* (2005). The problem of Child Sexual Abuse/ Response. *Science, 309*, 1182-1185.

Finkelhor, D., Hotaling, G., Lewis, I. A., & Smith, C. (1990). Sexual abuse in a national survey of adult men and women: Prevalence, characteristics, and risk factors. *Child Abuse & Neglect, 14*, 19-28.

Finkelhor, D. & Baron, L. (1986). Risk factors for child sexual abuse. *Journal of Interpersonal Violence 1(1)*, 43- 71.

Fonagy, P. & Bateman, A. (2008). The Development of Borderline Personality Disorder- A Mentalizing Model. *Journal of Personality Disorders, 22(1)*, 4-21.

Fonagy, P., Gergely, G., Jurist, E. T. & Target, M. (2002). *Affect Regulation, Mentalization, and the Development of the Self*. New York: Other Press.

Foynes, M. M., Freyd, J. J. & DePrince, A. P. (2009). Child abuse: Betrayal and disclosure. *Child Abuse & Neglect 33(4)*, 209-217.

Frenken, J. & van Stolk, B. (1990). Incest victims: Inadequate help by professionals. *Child Abuse & Neglect 14(2)*, 253-263.

Freyd, J. J. (1996). *Betrayal trauma: The logic of forgetting childhood abuse*. Cambridge, MA: Harvard University Press.

Fricker, A. E., Smith, D. W., Davis, J. L., & Hanson, R. F. (2003). Effects of context and question type on endorsement of childhood sexual abuse. *Journal Of Traumatic Stress 16(3)*, 265-268.

Gallop, R., McCay, E., Guha, M. & Khan, P. (1999). The experience of hospitalization and restraint of women who have a history of childhood sexual abuse. *Health Care for Women International 20(4)*, 401 - 416.

Glaser, B. G. & Strauss, A. L. (1970). *Anguish: a case history of a dying trajectory*. London, Martin Robertson.

Glaser, B.G. & Strauss, A.L. (1967*). The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine.

Goodman-Brown, T. B., Edelstein, R. S., Goodman, G. S., Jones, D. P. H., & Gordon, D. S. (2003). Why children tell: a model of children's disclosure of sexual abuse. *Child Abuse & Neglect 27(5)*, 525-540.

Gore-Felton, C., Arnow, B., Koopman, C., Thoresen, C. & Spiegel, D. (1999). Psychologists' beliefs about the prevalence of childhood sexual abuse: the influence of sexual abuse history, gender, and theoretical orientation. *Child Abuse & Neglect 23(8)*, 803-811.

Greenberg, J. B. (2001). Childhood sexual abuse and sexually transmitted diseases in adults: A review of and implications for STD/HIV programmes. *International Journal of STD & AIDS 12(12)*, 777- 784.

Griffing, S., Ragin, D. F., Morrison, S., Sage, R. E., Madry, L. & Primm, B. J. (2005). Reasons for Returning to Abusive Relationships: Effects of Prior Victimization. *Journal of Family Violence 20(5)*, 341-348.

Grimmer, A. & Tribe, R. (2001). Counselling psychologists' perceptions of the impact of mandatory personal therapy on professional development: An exploratory study. *Counselling Psychology Quarterly 14(4)*, 287-301.

Gubrium, J. F. (1994). Interviewing. In B. F. Crabtree, W. L. Miller et al (Eds.). *Collaborative Research in Primary Care*, (pp. 65-76). Thousand Oaks, CA: Sage Publications.

Hamby, S. & Gray-Little, B. (2000). Labeling Partner Violence: When Do Victims Differentiate Among Acts? *Violence and Victims 15(2)*, 173-186.

Hanson, R. F., Resnick, H. S., Saunders, B. E., Kilpatrick, D. G. & Best, C. (1999). Factors related to the reporting of childhood rape. *Child Abuse & Neglect 23(6)*, 559-569.

Harris, M. & Fallot, R. D. (2001). Envisioning a trauma-informed service system: A vital paradigm shift. *New Directions for Mental Health Services 2001(89)*, 3-22.

Harrison, R. L. & Westwood, M. J. (2009). Preventing vicarious traumatization of mental health therapists: Identifying protective practices. *Psychotherapy: Theory, Research, Practice, Training 46(2)*, 203-219.

Herman, J. L. (1992). *Trauma and Recovery.* New York: Basic Books.

Hernandez, P., Gangsei, D. & Engstrom, D. (2007). Vicarious resilience: a new concept in work with those who survive trauma. *Family Process 46(2)*, 229-241.

Hill, J., Davis, R., Byatt, M. Burnside, E., Rollinson, L., & Fear, S. (2000). Childhood sexual abuse and affective symptoms in women: a general population study. *Psychological Medicine 30(6)*, 1283-1291.

Hodas, G. R. (2004). *Responding to childhood trauma: The promise and practice of trauma informed care*. Pennsylvania: Office of Mental Health and Substance Abuse Services. pp.1-77.

Hollingsworth, M. A. (1993). Responses to female therapists to treating adult female survivors of incest. *Dissertation Abstracts International, 54 (6-B)*, 3342B.

Holmes, G. & Offen, L. (1996). Clinicians' hypotheses regarding clients' problems: Are they less likely to hypothesize sexual abuse in male compared to female clients? *Child Abuse & Neglect 20(6)*, 493-501.

Hubbard, G., Backet-Milburn, K. *et al*. (2001). Working with emotion: Issues for the researcher in fieldwork and teamwork. *International Journal of Social Research Methodology: Theory & Practice 42(2)*, 119-137.

Huey, D. A. & Britton, P. G. (2002). A portrait of clinical psychology. *Journal of Interprofessional Care 16(1)*, 69-78.

Jacobson, A. & Richardson, B. (1987). Assault experiences of 100 psychiatric inpatients: evidence of the need for routine inquiry. *American Journal of Psychiatry 144(7)*, 908-913.

Jefferson, G. (2004). Glossary of transcript symbols with and Introduction.In G. H. Lerner. *Conversation Analysis: Studies from the first generation.* Philadelphia: John Benjamins. pp 13-23.

Jones, D. P. H. (2000). Editorial: disclosure of child sexual abuse. *Child Abuse & Neglect 24(2)*, 269-271.

Knight, C. (1997). Therapists' affective reactions to working with adult survivors of child sexual abuse: An exploratory study. *Journal of Child Sexual Abuse 6(2)*, 17-41.

Kuyken, W. & Brewin, C. R. (1999). The Relation of Early Abuse to Cognition and Coping in Depression. *Cognitive Therapy & Research 23(6)*, 665-677.

Lab, D. D., Feigenbaum J. D. *et al*. (2000). Mental health professionals' attitudes and practices towards male childhood sexual abuse. *Child Abuse & Neglect 24(3)*, 391-409.

Lamb S. & Edgar-Smith, S. (1994). Aspects of Disclosure: Mediators of outcome of Childhood Sexual Abuse. *Journal of Interpersonal Violence 9(3)*, 307-326.

Lechner, M. E., Vogel, M. E., Garcia-Shelton, L. M., Leichter, J. L., & Steibel, K. R. (1993). Self-reported medical problems of adult female survivors of childhood sexual abuse. *The Journal of Family Practice. 36(6)*, 633-638.

Lincoln, Y. S. & Guba, E. G. (1985). *Naturalistic Inquiry*. Beverly Hills, CA: Sage

Lindblad, F. (2007). Reflections on the concept of disclosure. In M. E. Pipe, M.E. Lamb *et al. Child sexual abuse: Disclosure, delay, and denial.* Mahwah, NJ: Lawrence Erlbaum. pp. 291-301.

Lothian, J. & Read, J. (2002). Asking about abuse during mental health assessments: Clients' views and experiences. *New Zealand Journal of Psychology 31(2)*, 98- 104.

Lucenko, B. A., Gold, S. N. & Cott, M. A. (2000). Relationship to Perpetrator and Posttraumatic Symptomatology Among Sexual Abuse Survivors. *Journal of Family Violence 15(2)*, 169-179.

Marriage, S. & Marriage, K. (2005). Too Many Sad Stories: Clinician Stress and Coping. *The Canadian Child and Adolescent Psychiatry Review, 14 (4)*, 114- 117.

Maslach, C., Schaufeli, W. B. *et al.* (2001). Job burnout. *Annual Review of Psychology 52*, 397-422.

McCann, L. I. & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. J*ournal of Traumatic Stress. 3(1),* 131-149.

McGhee, H., Garavan, R., de Barra, M., Byrne, J. & Conroy, R. (2002). *The SAVI Report: Sexual Abuse and Violence in Ireland; a national study of Irish experiences, Beliefs and Attitudes Concerning Sexual Violence*. Dublin Rape Crisis, Dublin: Liffey Press.

McNulty, C. & Wardle, J. (1994). Adult disclosure of sexual abuse: A primary cause of psychological distress? *Child Abuse & Neglect 18(7)*, 549-555.

Mikulincer, M., Shaver, P. R. & Pereg, D. (2003). Attachment Theory and Affect Regulation: The Dynamics, Development, and Cognitive Consequences of Attachment-Related Strategies. *Motivation and Emotion, 27(2),* 77-102.

Mullen, P. E., Martin, J. L., Anderson, J. C., Romans, S. E. & Herbison, G. P. (1993). Childhood sexual abuse and mental health in adult life. *British Journal of Psychiatry 163*, 721-732.

Murray, J. B. (1993). Relationship of childhood sexual abuse to borderline personality disorder, posttraumatic stress disorder, and multiple personality disorder. *The Journal Of Psychology 127(6),* 657-676.

Nelson, S. (2009). *Care and support needs of men who survived childhood sexual abuse: Report of a qualitative research project*. Edinburgh: Centre for Research on Families and Relationships.

Nelson, S. & Hampson, S. (2008). *Yes You Can! - Working with Survivors of Childhood Sexual Abuse.* Edinburgh: Scottish Government.

Nelson, S. & Phillips, S. (2001). *Beyond Trauma: Mental Health Care Needs of Women Who Have Survived Childhood Sexual Abuse*. Edinburgh: The University of Edinburgh.

Noell, J., Rohde, P., Seeley, J. & Ochs, L. (2001). Childhood sexual abuse, adolescent sexual coercion and sexually transmitted infection acquisition among homeless female adolescents. *Child Abuse & Neglect 25(1),* 137-148.

Orb, A., Eisenhauer, L. & Wynaden, D. (2000). Ethics in Qualitative Research. *Journal of Nursing Scholarship 33(1),* 93-96.

Pearlman, L. A. & McCann, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice 26(6),* 558-565.

Pilgrim, D. & Treacher, A. (1992). *Clinical Psychology Observed*. London: Tavistock/ Routledge.

Priebe, G. & Svedin, C. G. (2008). Child sexual abuse is largely hidden from the adult society: An epidemiological study of adolescents' disclosures. *Child Abuse & Neglect 32(12),* 1095-1108.

Pruitt, J. A. & Kappius, R. E. (1992). Routine inquiry into sexual victimization: A survey of therapists' practices. *Professional Psychology: Research and Practice 23(6),* 474-479.

QSR (2009-2010). *NVivo 8*. www.qsrinternational.com. QSR International: Australia.

Read, J., Hammersley, P. & Rudegeair, T. (2007). Why, when and how to ask about childhood abuse. *Advances in Psychiatric Treatment 13(2),* 101-110.

Read, J., van Os, J., Morrison, A. P. & Ross, C. A. (2005). Childhood trauma, psychosis and schizophrenia: a literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica 112(5),* 330-350.

Read, J., Agar, K., Barker-Collo, S., Davies, E. & Moskowitz, A. (2001). Assessing Suicidality in Adults: Integrating Childhood Trauma as a Major Risk Factor. *Professional Psychology: Research and Practice, 32(4),* 367-372.

Read, J. & Fraser, A. (1998). Abuse Histories of Psychiatric Inpatients: To Ask or Not to Ask? *Psychiatric Services 49(3),* 355-359.

Roesler, T. A. & Wind, T. W. (1994). Telling the secret: Adult women describe their disclosures of incest. *Journal of Interpersonal Violence, 9,* 327-338.

Romans, S. E., Gendall, K. A., Martin, J. L. & Mullen, P. E. (2001). Child sexual abuse and later disordered eating: a New Zealand epidemiological study. *The International Journal Of Eating Disorders 29(4),* 380-392.

Rupert, P. A., & Morgan, D. J. (2005). Work setting and burnout among professional psychologists. *Professional Psychology: Research and Practice, 36,* 544-550.

Russell, D. F. H. (1986). The secret trauma: Incest in the lives of girls and women. New York: Basic Books.

Salston, M. & Figley, C. R. (2003). Secondary Traumatic Stress Effects of Working with Survivors of Criminal Victimization. *Journal of Traumatic Stress 16(2),* 167-174.

Saunders, B. E., Villeponteaux, L. A., Lipovsky, J. A., & Kilpatrick, D. G. (1992). Child sexual assault as a risk factor for mental disorder among women: A community survey. *Journal of Interpersonal Violence, 7 (2)*, 189-204.

Schauben, L. J. & Frazier, P. A. (1995). Vicarious trauma: The effects on female counsellors of working with sexual violence survivors. *Psychology of Women Quarterly, 19(3),* 49-64.

Schaufeli, W. B., Maslach, C. & Tadeuz, M. (1993). *Professional burnout: Recent developments in theory and research.* Philadelphia: Taylor & Francis.

Scottish Executive (2008). *Gender Based Violence Action Plan: Guidance for Health Boards.* Edinburgh: The Scottish Executive Health Department

Scottish Executive (2006). *Delivering For Mental Health.* Edinburgh: Scottish Executive Health Department.

Scottish Executive (2005). *Survivor Scotland: A Survivor-Centred Strategic Approach for Survivors of Childhood Sexual Abuse.* Edinburgh: Scottish Executive.

Scottish Executive, Short Life Working Group (2005). Report on the care needs of people who have survived childhood sexual abuse. Scottish Executive: Edinburgh.

Scottish Executive (2003). Mental Health (Care & Treatment) Act (Scotland). Scottish Executive: Edinburgh.

Seidman, I. (2006). *Interviewing as qualitative research: A guide for researchers in education and the social sciences.* New York: Teachers College Press.

Sharpe, D. & Faye, C. (2006). Non-epileptic seizures and child sexual abuse: A critical review of the literature. *Clinical Psychology Review 26(8),* 1020-1040.

Simpson, T. L. & Miller, W. R. (2002). Concomitance between childhood sexual and physical abuse and substance use problems: A review. *Clinical Psychology Review 22(1),* 27-77.

Smith, D. W., Letourneau, E. J., Saunders, B. E., Kilpatrick, D. G., Resnick, H. S. & Best, C. L. (2000). Delay in disclosure of childhood rape: results from a national survey. *Child Abuse & Neglect 24(2*), 273-287.

Soderstrom, K. & Skarderud, F. (2009). Minding the Baby: Mentalization-based treatment in Families with Parental Substance Use Disorder: Theoretical Framework. *Nordic Psychology, 61(3),* 47-65.

Somer, E. & Szwarcberg, S. (2001). Variables in Delayed Disclosure of Childhood Sexual Abuse. *American Journal of Orthopsychiatry 71(3),* 332-341.

Sorsoli, L., Kia-Keating, M. & Grossman, F. K. (2008). "I keep that hush-hush": Male survivors of sexual abuse and the challenges of disclosure. *Journal of Counseling Psychology 55(3),* 333-345.

Spiegel, J. (2003). *Sexual Abuse of Males: The SAM model of theory and practice.* New York: Brunner-Routledge.

Strauss, A. L. & Corbin, J. (1990). *Basics of Qualitative Research: Grounded Theory Procedures and Techniques.* Newbury Park, CA: Sage.

Swift, W., Copeland, J. & Hall, W. (1996). Characteristics of women with alcohol and other drug problems: findings of an Australian national survey. *Addiction, 91*, 1141-1150.

Tabachnick, B. G. & Pope, K. S. (1997). Therapist responses to recovered and never forgotten memories of child sex abuse: A national survey of licsenced psychologists. *Violence Against Women, 3*, 348-360.

Wenninger, K. & Ehlers, A. (1998). Dysfunctional Cognitions and Adult Psychological Functioning in Child Sexual Abuse Survivors. *Journal Of Traumatic Stress 11(2)*, 281-300.

World Health Organisation (2002). *World Report on Violence and Health.* Geneva: World Health Organisation.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health 15(2),* 215-228.

Young, M., Read, J., Barker-Collo, S. & Harrison, R. (2001). Evaluating and overcoming barriers to taking abuse histories. *Professional Psychology: Research and Practice 32(4),* 407-414.

5: Appendices

5.1: Appendix 1- Information Form for Participants

INFORMATION FORM FOR PARTICIPANTS

Dear Colleague

Project Title:
CSA Disclosures in Adult Clinical Practice: Inquiry and Response.

I am currently doing a doctorate in clinical psychology in affiliation with Edinburgh University and NHS Fife Department of Clinical Psychology. I am conducting a research study in accordance with my training and I am inviting psychologists to take part in my study. My area of interest is therapy with **adult** survivors of Child Sexual Abuse (CSA).

My study aims to ask psychologists about the experience of inquiring into a client's history of CSA and responding to disclosures of CSA.

I am recruiting individuals who:

- Hold a therapeutic role within the Department of Clinical Psychology, NHS Fife,
- Have had at least two years experience (post-relevant qualification) of working with service-users **aged 16+** years who have disclosed CSA within the last 6 months.

If you have not worked with adults for two years post qualification or do not wish to participate, please discard this letter and information sheet.

I would be grateful if you would take the time to read the enclosed information and think about whether or not you would be willing to participate in this study. If you agree to participate, please return your completed consent form in the separate envelope provided. Please return this as soon as possible but no later than **3 weeks**. If you are not interested in participating, please discard this information pack or return it blank.

If you have any queries, please do not hesitate to contact me using the details provided in the enclosed information sheet.

I would like to thank you for your time.

Yours sincerely,

Emma Ross

Trainee Clinical Psychologist

CSA Disclosures in Adult Clinical Practice: Inquiry and Response.

I would like to invite you to participate in a research project, which I believe to be of potential importance. However, before you decide whether or not you wish to take part, I need to be sure that you understand why I am doing this research and what you would be required to do should you agree to participate. Therefore, I am providing you with the following information. Please read it carefully and be sure to ask any questions that you may have and, if you want, to discuss it with others. We will do our best to explain and to provide you with any further information you may ask for, now or later. You do not have to make an immediate decision.

Background to the Study

This study is being conducted through the Clinical Psychology Department in Fife and the University of Edinburgh (the project's sponsor). It will form the thesis that will be submitted for the degree of Doctor of Clinical Psychology for myself, Emma Ross. We are conducting research into how clients disclose to their psychologists that they are survivors of Child Sexual Abuse (CSA), what these disclosures are like for psychologists, what factors are important in how psychologists ask about CSA, and how they respond to a disclosure of CSA. I aim to interview approximately 10 psychologists.

What does the study involve?

If you agree to participate in the study, we would like to ask you some questions about CSA disclosure and response. This would involve meeting with the principle researcher (Emma Ross) and having an interview. It is expected that this would last for approximately one hour.

I aim to interview approximately 10 psychologists for about an hour for each interview. Interviews will take place at the Clinical Psychology Departments at Lynebank and Stratheden Hospital by appointment. However, if this is not convenient for you I am happy to discuss an alternative that is more suitable for you. Once the data reaches a point of "saturation" (i.e. where no novel data is forthcoming from interviews), participant recruitment will cease. This means that I may not require as many as 10 participants and in this case, any participant who has not yet been interviewed would be advised that their participation would no longer be required.

What are the potential discomforts, risks and side effects?

Questions will not include the discussion of personal history and will not expect participants to discuss clients' details of childhood sexual abuse.

You will not be asked to discuss your own personal history and I do not expect you to discuss histories of CSA. I am interested in the experience of enquiry into whether a client has experienced CSA and how psychologists respond to CSA disclosure. I do not wish to cause you discomfort or distress. I am aware that the issue of disclosing CSA can be upsetting for both clients and psychologists.

Do I have to take part?

It is up to you whether or not you decide to take part in the study. If you do, you will be given this information sheet and you will be asked to sign a consent form. You will be free to withdraw at any time without having to give a reason. A decision not to take part or to withdraw at a later stage will not affect any aspect of your work in NHS Fife

What will happen to the information collected in the study?

If you agree to take part in the study, all of the information about you and the responses you give will be confidential. No names or personal information will be used in the write up of this study. Digital recordings of interviews will be transferred to audio compact disk and will be stored within a locked filing cabinet in the psychology department. Once interviews have been anonymously transcribed, they will be destroyed. The information you give will be collated with other interview transcripts and your quotes will be anonymised. Anonymised transcripts will be stored in a locked filing cabinet and on a password protected computer file. Transcripts will be retained for a five year period and then destroyed.

This data will be analysed according to principles of Grounded Theory in order to better understand the experience of CSA disclosure for psychologists and how the enquiry into CSA history may have an effect on the therapeutic relationship.

All responses will be treated with the strictest of confidentiality, there will be no reason to break confidentiality unless the researcher believes that there is the presence of risk (such as suicide, self harm, neglect or risks to your own or others well being), **or** the unless researcher believes that there is evidence of behaviour which constitutes a breach of British Psychological Society 'guidelines of professional practice' (BPS, 1995). In these instances, information will be shared with the clinical supervisor and may also be shared with the psychologist's line manager.

Your rights

Participation in the study is entirely voluntary and you are free to refuse to take part or to withdraw from the study at any time without having to give a reason. Your decision to take part or not will not be known by anyone other than myself. If you would like a copy of the overall results from the study, you can obtain this on request using the details below. The study will be completed by August 2010.

The Fife & Forth Valley Research Ethics Committee, which has responsibility for scrutinising all proposals for medical research on humans in Fife and Forth Valley, has examined the proposal and has raised no objections from the point of view of medical ethics. It is a requirement that your records in this research be made available for scrutiny by monitors from the University of Edinburgh and NHS Fife, whose role is to check that research is properly conducted and the interests of those taking part are adequately protected.

Contact Details

If you have any difficulties or further questions please contact me on the number below, or leave a message for me to get back to you.

Ms Emma Ross (NHS Fife)

Chief Investigator and Trainee Clinical Psychologist

Telephone: 01383 565 402

Ms Fara McAfee (NHS Fife)

Clinical Research Supervisor and Clinical Psychologist

Telephone: 01383 565 402

Dr David Gillanders (University of Edinburgh)

Academic Research Supervisor and Clinical Psychologist

Telephone: 0131 651 3972

Independent Contact

If you would like to make any comments or seek **independent** advice about this study:

Dr Ethel Quayle (University of Edinburgh)

0131 651 3980

Dr Thomas Godsen (NHS Fife)

Clinical Psychologist

01334 696 336

Thank you for taking the time to read this Information Sheet and for considering taking part on this study.

Reference

The British Psychological Society (1995). *Professional Practice Guidelines: Division of Clinical Psychology*. Leicester: BPS

5.2: Appendix 2- Participant Consent Form

CONSENT FORM FOR PARTICIPANTS

Title of Project: CSA Disclosures in Adult Clinical Practice: Inquiry and Response.

Name of Researcher: Ms Emma M H Ross

Please initial box

1. I confirm that I have read and understand the information sheet dated 14.10.09 (Version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation in this RESEARCH is voluntary and that I am free to withdraw at any time without giving any reason. ☐

3. I understand that the relevant sections of my data collected during the study may be looked at by individuals from Edinburgh University Research and Governance Office, from regulatory authorities or from NHS Fife, where it is relevant to my taking part in this research. The Chief Investigator (Emma Ross), Academic Supervisor (Dr David Gillanders) and Clinical Supervisor (Fara McAfee) will have access to the data collected. I give permission for these individuals to access this data. **All data will be anonymised.** ☐

4. I have been made aware that direct quotes may be used in the write up of the research. These quotes will be anonymised. I agree to the use of direct quotes. ☐

5. I agree to my interview being digitally recorder. I understand that this recording will be destroyed once it has been transcribed ☐

_____	_____	_____
Name of Participant	Date	Signature
Emma M H Ross	_____	_____
Name of Principal Researcher	Date	Signature

5.3: Appendix 3- University of Edinburgh Clinical Psychology Programme Team Ethics Approval

UNIVERSITY OF EDINBURGH / NHS (SCOTLAND) CLINICAL PSYCHOLOGY TRAINING COURSE

Research Ethics Meeting 1.6.09

Present:	**Apologies:**
Paul Morris	Lindsey Murray
Emily Newman	
Ethel Quayle	
Eleanor Sutton	
Suzanne O'Rourke	

Emma Ross.

This was thought to be an interesting thesis proposal. The following suggestions were made by the Committee in relation to ethical and research issues and these should be addressed. The Committee does not require resubmission of the proposal.

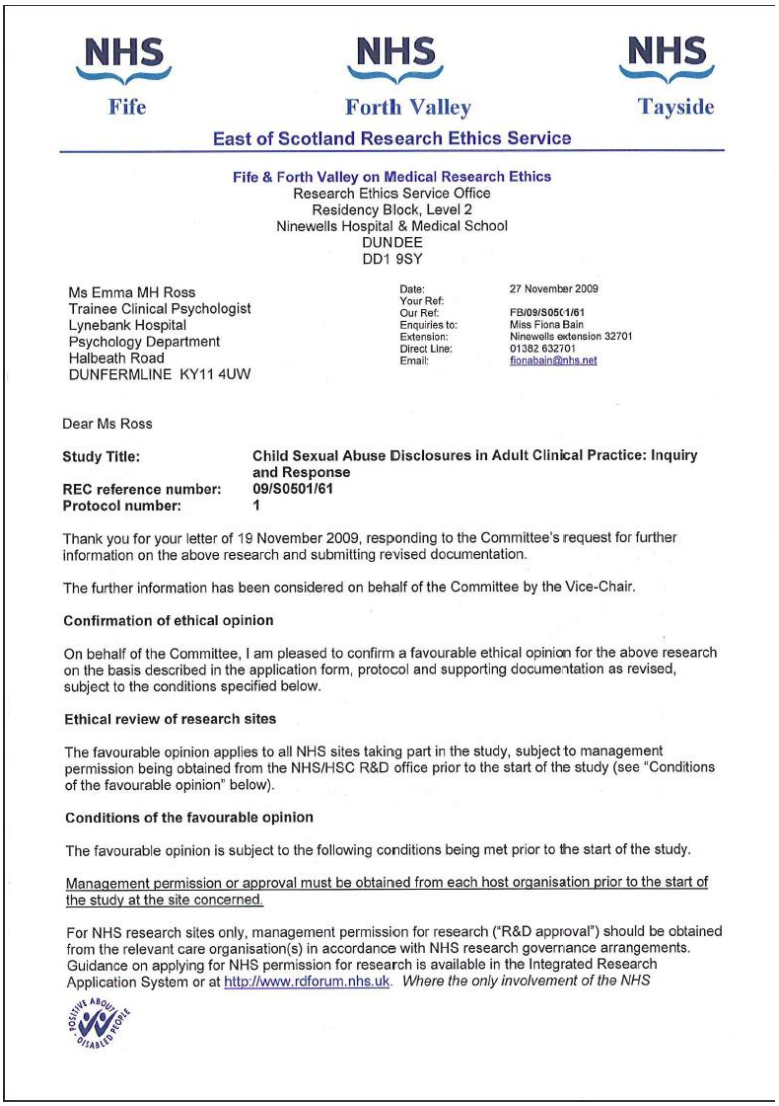
Ethics

- Reference should be made that if participants withdraw from the study their data will be removed.
- The title should include Adult Clinical Practice.
- There should be reference to the availability of clinical supervision in case of vicarious traumatisation.

Research

- Reference is made in the text to CBT therapist or psychologist. Please clarify what is meant and use consistently.
- The interview schedule was considered to be somewhat unfocused and it was not clear how it would address the primary research question.
- There needs to be justification for the use of GT and it is unclear what the proposed research would generate a theory in relation to.
- The use of NVivo as a data organising tool needs to be clarified as this software does not analyse data.

5.4: Appendix 4- NHS Research Ethics Committee Letter of Favourable Opinion



NHS Fife | NHS Forth Valley | NHS Tayside

East of Scotland Research Ethics Service

Fife & Forth Valley on Medical Research Ethics
Research Ethics Service Office
Residency Block, Level 2
Ninewells Hospital & Medical School
DUNDEE
DD1 9SY

Ms Emma MH Ross
Trainee Clinical Psychologist
Lynebank Hospital
Psychology Department
Halbeath Road
DUNFERMLINE KY11 4UW

Date: 27 November 2009
Your Ref:
Our Ref: FB/09/S0501/61
Enquiries to: Miss Fiona Bain
Extension: Ninewells extension 32701
Direct Line: 01382 632701
Email: fionabain@nhs.net

Dear Ms Ross

Study Title: **Child Sexual Abuse Disclosures in Adult Clinical Practice: Inquiry and Response**
REC reference number: **09/S0501/61**
Protocol number: **1**

Thank you for your letter of 19 November 2009, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Vice-Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk. *Where the only involvement of the NHS*

organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Professional Indemnity Insurance - renewal date: 01 August 2010		27 July 2009
Summary CV for Supervisor (student research)		
Covering Letter		31 August 2009
REC application		04 August 2009
Protocol	1	31 August 2009
Investigator CV		31 August 2009
Letter from Sponsor		31 August 2009
Interview Schedules/Topic Guides	1	24 August 2009
Response to Request for Further Information		19 November 2009
Covering Letter		19 November 2009
Participant Information Sheet	2	14 October 2009
Participant Consent Form	2	14 October 2009

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

09/S0501/61	Please quote this number on all correspondence

Yours sincerely

Mr Gavin Costa
Chair

Enclosures: "After ethical review – guidance for researchers"

Copy to: Elspeth Currie
Research Governance Manager
Queen's Medical Research Institute
47 Little France Crescent
Edinburgh
EH16 4TJ

Dr Amanda Wood, NHS Fife R&D office

5.5: Appendix 5 - NHS Management Approval of Research Study

NHS
Fife

Ms Emma Ross
Trainee Clinical Psychologist
Psychology Dept
Lynebank Hospital
DUNFERMLINE

Medical Director, Primary Care
Room 3/3
Hayfield House
Hayfield Road
KIRKCALDY
Fife KY2 5AH
Tel 01592 643355
www.show.scot.nhs.uk/fpct

Date 22 December 2009
Our Ref 09-098 09/S0501/61
Enquiries to Aileen Yell
Tel No 01383 565110
Email aileen.yell@fahf.scot.nhs.uk

Dear Ms Ross

Project Title: Child sexual abuse disclosure in adult clinical practice : inquiry and response

Thank you for your application to carry out the above project. Your project documentation (detailed below) has been reviewed for resource and financial implications for NHS Fife Operational Division and I am happy to inform you that Management Approval has been granted.

Approved documents

Document	Version	Date
Protocol	1	31 August 2009
REC application		4 August 2009
Investigator CV		31 August 2009
Letter from Sponsor		31 August 2009
Various documentation detailed in favourable ethical opinion letter		
Ethics letter		27 November 2009

The sponsors for this study are University of Edinburgh.

Details of our participation in studies will be included in annual returns we are expected to complete as part of our agreement with the Chief Scientist Office. Regular reports of the study require to be submitted. Your first report should be submitted to Dr A Wood, R&D Manager, R&D Resource Centre, Lynebank Hospital, Halbeath Rd, Dunfermline, KY11 4UW (Amanda.wood3@nhs.net) in 12 months time and subsequently at yearly intervals until the work is completed.

In addition, approval is granted subject to the following conditions:-

- All research activity must comply with the standards detailed in the Research Governance Framework for Health & Community Care (http://www.sehd.scot.nhs.uk/cso/), health & safety regulations, data protection principles, other appropriate statutory legislation and in accordance with Good Clinical Practice (GCP).
- Any amendments which may subsequently be made to the study should also be notified to Aileen Yell, Research Governance Officer (aileenyell@nhs.net), as well as the appropriate regulatory authorities.
- You will be required to assist with and provide information in regard to monitoring and study outcomes

- As custodian of the information collated during this research project you are responsible for ensuring the security of all personal information collected in line with NHS Scotland IT Security Policies, until the destruction of this data.

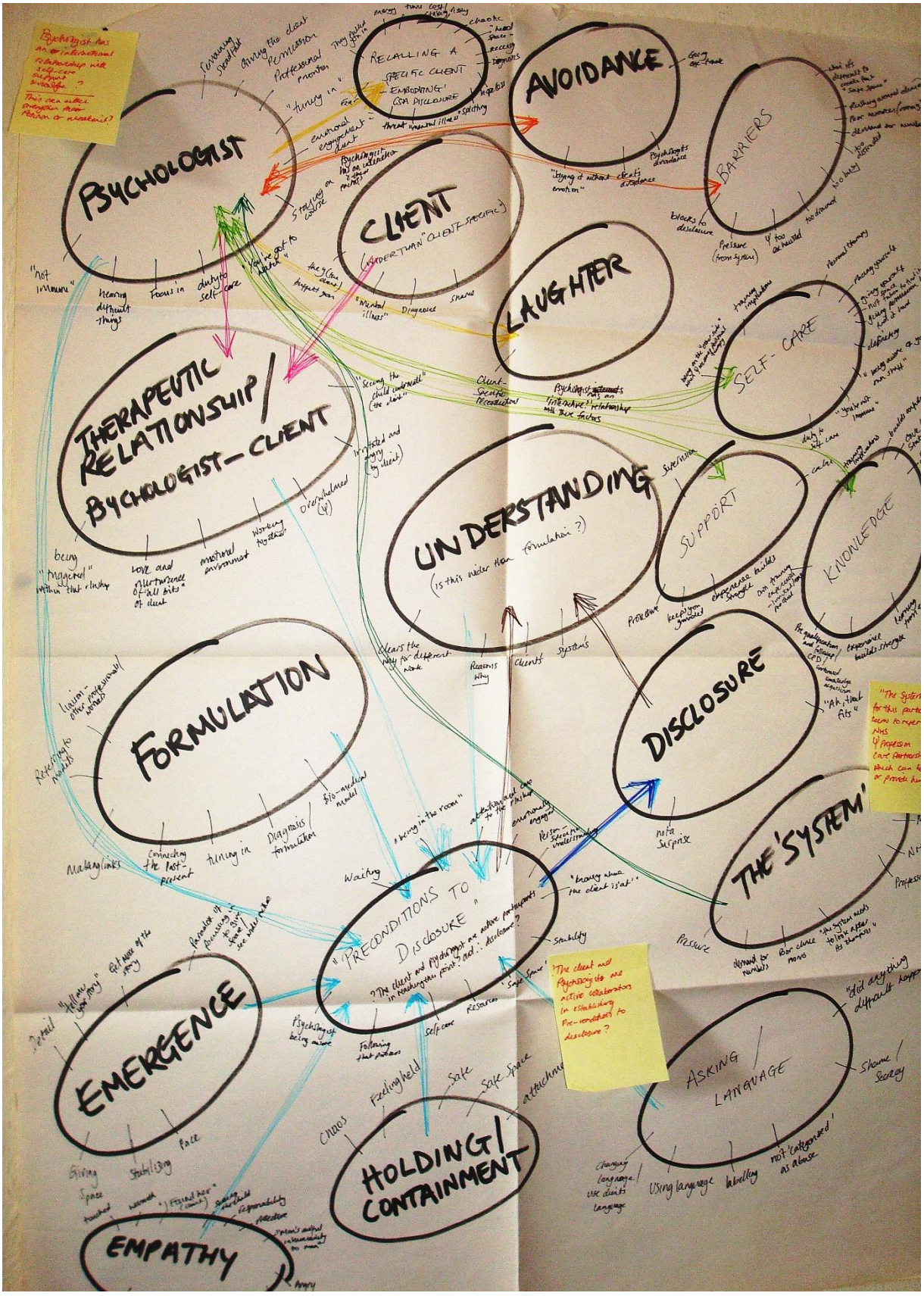
I would like to wish you every success with your study and look forward to receiving a summary of the findings for dissemination once the project is complete.

DR STELLA CLARK
Medical Director, Primary Care
NHS Fife

Cc : Aileen Yell, Research Governance Officer, NHS Fife, Lynebank Hospital, Dunfermline
Pamela Sharpe, NHS Research Scotland C, R&D Office, Foresterhill House Annex, Foresterhill, AberdeenAB25 2ZB

Ver 1 - 01.11.08

5.6: *Appendix 6- Example of Diagrammatic Clustering*



5.7: Appendix 7- Section from Reflective Journal

January '10

"Participants describe this process of "holding" the client steady, providing a safe and containing relationship and yet trying to drive them forward to a place where they can disclose their abuse. This seems like a model of trauma therapy to me. Rather than Herman's ***[Herman, 1992]*** *staged model of trauma reprocessing, there is much more of a fluid 'back and forth' between emotional regulation/ stability and change. Codes such as "seeing the child* ***[in the adult client]"****, "holding the client in mind" seem to link with psychodynamically & attachment-informed approaches such as Schema Therapy and Transactional Analysis. Despite participants explaining that they have had little (or no) formal training in working with CSA survivors and their disclosures- it looks like they have constructed their own working models."*